UNDERSTANDING PREVENTIVE COMMUNITY HEALTH SERVICES FOR PRE-SCHOOL CHILDREN: ORIGINS, POLICY AND CURRENT PRACTICE

LOUISE JANE CONDON

A dissertation submitted to the University of Bristol in accordance with the requirements of the degree of Doctor of Philosophy in the Faculty of Social Sciences and Law,
School for Policy Studies

79, 887 words

June 2009

0.1 Abstract

Community health services for pre-school children have been the major universal health provision for well-children for over a hundred years. Traditionally these services have been largely delivered by health visitors, who are now community nurses with a specialist post-graduate qualification. Preventive health services for children in the UK have been increasingly criticised as insufficiently evidence-based. Criticism has led to reform of national policy and subsequent major changes to existing services, particularly in targeting services to those with the highest health and social needs. The effect of these policy changes upon the service provided for pre-school children by health visitors is not known.

This thesis explores the origins and development of children's preventive health services and examines the effect of post-1989 policy changes in practice, in particular the move to a predominately targeted child health promotion programme. The empirical study used a mixed methods approach to investigate changes to local policy and practice. A national survey was made of health visitors' child health promotion practice (n=1043) which was followed by an in-depth interview study (n=25) of health visitors' views on service changes.

Study findings illuminate the effect of post-1989 reforms on child health services, showing a diversity of practice across the country, and resistance to key aspects of policy and practice among health visitors. Despite a revised national child health promotion programme being published in April 2008, which addresses some of the areas of concern highlighted by this study, flaws remain which have implications for the successful implementation of this programme. These flaws reflect wider contentious issues in NHS policy-making, related to the distribution of power and resources between different professional groups within the NHS and service users. Failing to explore

these issues in policy and practice reduces the ability of preventive health services to maintain and improve pre-school children's health.

ACKNOWLEDGEMENTS

Great thanks are due to the following people:

- My supervisors, Professor Elaine Farmer and Professor Lesley Doyal, who have been unfailingly enthusiastic and inspiring, from the very first stirrings of this project right through to its completion.
- Sue Browne for her indignation about the consequences of reduced routine child health surveillance, which gave me the impetus to start this project.
- All the health visitors who took part in the survey and interviews.
- The late Gill Hek for her encouragement of me as a researcher.

Invaluable practical help was gratefully received from the following:

- Funding for the survey was given by the Community Practitioners and Health Visitors' Association (Lady Limerick Award), and raised from subscription by members. The Bristol, Gloucestershire, Bath and Swindon Primary Care Network also provided research funding.
- Technical advice was given by: Dr Jenny Ingram (UBHT Research and Development Unit), statisticians Dr Tony Hughes, Dr Rosemary Greenwood (University of Bristol) and Dr Kathy Pollard (University of the West of England), and librarians, Jason Ovens (Bristol PCT), and Jason Briddon (University of the West of England).
- Susan Field, Director of Nursing, secured an annual contribution to fees from Bristol PCT.
- Jane Thomas and Lesley Hood assisted in mailings, Mark Condon with recordings, and Joan Newcombe with proof reading.

Many friends, relations and colleagues have sustained patient interest in this project over the last 6 years. These include: Alan Newcombe, Elizabeth Condon, Gay and Liz Whelan, Francesca Harris, Jennie Peacock, Sue Pryse-Davies, Jean Scott, Carol Beddows, Cheryl Flynn, Kimberley Hutchings, Edmund and Vivienne Lodite, Bridget Caird, Nicki Symes, Sally Tedstone, Maggie and Graham Stuart, Paul Roberts, Pam Cairns, Patricia Holroyd, Terry and Stella Tratt, Holly Brennan, Andrea Muxworthy, Julian and Lynn Sawyer, Liz and Mervin Bramley, Colin Havell, Sarah Fry, Claire Marrack, Angie Benoy, Kate White, Anne Barwell, Sandy Hollinghurst, Yvonne Reed, Jenny Taylor, Jenny Spencer, Biddy Jones, Annette Marshall, Carol Marks and Sarah Hadden.

Finally, but perhaps most of all, thanks are due to my family, Tony, Helen, Sean, Mark and Tess, for living with this project for so long and putting up with its many demands upon time, computer access, and finances. Special mention must be made of Tess, who was often tied to my desk, when she would much rather have gone for a walk.

I declare that the work in this dissertation was carried out in accordance with the Regulations of the University of Bristol. The work is original, except where indicated by special reference in the text, and no part of the dissertation has been submitted for any other academic award. Any views expressed in the dissertation are those of the author:

SIGNED…….

DATE……..

CONTENTS

Chapter 3- Research Methods

Chapter 4 – Survey findings

Chapter 5 – Interview findings I: the CHPP and health needs

Chapter 6 – Interview findings II: organisational change and the use of resources

Chapter 7- Discussion

Appendices

2.1 Overview of the pre-school Child Health Promotion Programme (DH 2004a)

3.1 Survey questionnaire

3.2 Explanatory letter/ Information sheet (survey)

3.3 Reply slip

3.4 Reminder letter

3.5 Interview topic guide

3.6 Explanatory letter/ Information sheet (interviews)

4.1 Published article giving the survey findings

5.1 Participants' descriptions of clients

5.2 Participants' descriptions of clients' needs

5.3 Participants' descriptions of CHPP contacts

7.1 Changes to the CHPP (DH 2008a)

LIST OF TABLES AND FIGURES

Introduction

0.1 What are preventive health services for pre-school children?

The terms used to describe preventive services for children have changed periodically over time due to changes of emphasis in the focus of these services. Popular titles over the last 150 years include child welfare, child health surveillance, developmental screening and child health promotion. Each descriptive title is representative of contemporary dominant beliefs about how the health of children should be maintained and improved, and the place of the State in monitoring children's health and development. Shifts in ideology, both in views of children and childhood, and ideas about the function of preventive health services, lead to the need to redirect and rename services. In calling these services 'preventive health services for children' I have attempted to use a term which does not subscribe to the language of any professional group or to any particular ideological standpoint. This term has been used in the past by some commentators (Butler 1989), but is currently not in common use.

Kuo *et al* (2006) have recently completed a review of preventive health services for children in ten developed countries around the world. They use the umbrella term 'well-child care' to describe the services they are reviewing. Although preventive services have been considered in the past across a European stage (European Health Committee 1985), Kuo *et al*'s review is valuable because it is up to date and international. It is therefore useful in setting preventive health services for children in England within a world context. The stated aim of conducting this review was to compare the American system with that of other developed countries. Data was collected by key-informant interviews, key informants being those considered most knowledgeable about national child health care. Site visits were carried out in some countries, including England, by some of the authors, all of whom were paediatricians. These site visits included observation of the child health care

service in action, as well as face-to-face meetings with child health experts and policy leaders.

Well-child care is defined as preventive care for children that includes (Kuo *et al* 2006):

- Health supervision (e.g. anticipatory guidance on nutrition, elimination, sleep, discipline and injury prevention)
- Developmental surveillance and milestones
- Child and family psychosocial assessment
- Care coordination (such as oversight of referrals)
- Immunisations, physical examination and additional screening (including height, weight, vision and hearing)

The authors state that as well as having different structural approaches, delivery systems reflect varying national assumptions about what well-child care consists of and how it should be delivered. In the table below, which is adapted from Kuo *et al* (2006), I have reduced the comparison to six countries, which is sufficient to show the diversity of systems and where the English programme is similar to, or divergent from, other national systems. It will be noted that countries differ in terms of which personnel carry out aspects of the programme, the extent to which the family is involved, and the extent to which interventions are directed at a community rather than an individual level. There is also variation in the extent to which the well-child care system is either integrated with, or separate from, the main body of the country's health care system.

Table 0.1 Practice features of well-child care (WCC) and relationship to health care system in six countries[1]

Country	**First contact** (which professional is responsible for WCC and other primary care)	**Coordination** (the degree of coordination in elements of WCC, and between WCC and primary care (if divided)	**Family Centred** (the focus on family and a two-generational model of care)	**Community Oriented** (geographic distribution and the extent to which care is targeted to community needs)
Australia	Community based nurses for WCC; GPs for all other primary care	Little coordination between nurses and GPs	Nurses provide social support to all families in district	Child health centres target needs of catchment area
England	Targeted risk assessment by HV. GP and HV provide other primary care	Between GPs and HVs. HVs are linked to GPs and observe the family setting	HVs visit families with identified psychosocial needs	Little explicit community orientation with exception of Sure Start areas
Germany	GP for WCC and other primary care	WCC and primary care usually received from same doctor	Minimal explicit family orientation, apart from some 'social physicians'.	Little explicit community orientation
Japan	Nurses do developmental screening in health centres; paediatricians provide care in private practice and hospitals	Portable child health record (bashi techa) allows information sharing	Minimal explicit family orientation or two-generational care	Municipal differences in covered services because of financing, but not specifically a community HNA
Netherlands	CH doctors do development screening using nationally mandated von Wiechen tool	GPs and nurses provide preventive services	Minimal explicit family orientation	Little explicit community orientation
Sweden	Community based nurses provide WCC; GPs provide rest of primary care services	Nurses and GPs provide preventive health services including WCC	A direct two-generational approach for behaviour, development and social opportunities used	Family centres situated in local geographical contexts

[1] Adapted from Kuo *et al* (2006). Abbreviations given below.

Abbreviations
CH: child health
GP: general practice physician
HNA: health needs assessment
HV: health visitor
WCC: well-child care

The findings set out in the above table must be viewed with a certain amount of caution. From the ensuing account of the English preventive health service it will become apparent that the summary of the system presented above does not concur wholly with current practice. It may be that interviewing key informants who are child health experts and policy makers does not include a wide enough range of WCC stakeholders to gain a realistic picture of what is happening in a health service. The site visits were carried out by US paediatricians, so there may have been a slant towards presenting the views of doctors rather than nurses, and describing policy as it was stated than what was actually happening in practice. There is no mention of service users being asked about the service they received. The possible distinction between national policy and implemented practice is not made in Kuo *et al*'s (2006) article.

However, useful insights can be gained from examining Kuo *et al*'s (2006) comparisons. It will be noticed from the above table that England is similar to many other countries, in having a service which is delivered by community child health nurses (health visitors) in conjunction with general practice doctors. The mix of service provision between nurses and doctors varies between countries. At one extreme Germany has a system wholly delivered by doctors, while in Australia and Sweden nurses deliver the whole of the well-child care component. The level of skills required by doctors to carry out the programme range from those of a general practitioner to those of a paediatrician. For the most part both doctors and nurses are involved in both providing well-child care but some countries maintain separate preventive and curative systems.

What is done to children also differs. To take one example; in the Netherlands all children have a developmental assessment carried out by a doctor using a standardised tool, Japan also includes developmental screening in the programme (though carried out by nurses), and elsewhere developmental screening is not reported as happening. The focus of the programme, whether individualistic (based on the child and family) or community is variable. In some countries, such as Germany and the Netherlands, the child appears to be viewed in isolation, as an independent being removed from consideration of its family or local community. Sweden takes the most proactive approach by involving parents, and seeking to influence the social opportunities offered to children.

This variability between countries suggests that there is no one agreed way of providing children's preventive health services. While all these countries have programmes with the aim of promoting children's good health, there is little standardisation of structure or programme delivery between countries. It appears that the type of system delivered and by whom, is more affected by cultural factors (such as ideas about the place of the child within the society, and the level of resources each country is willing to devote to the service) than by any established or universally recognised knowledge about what is the best way of meeting children's preventive health needs.

When England is compared with the other countries in Table 0.1, it can be seen to be completely at odds with all other countries in carrying out a targeted assessment at the first contact. Kuo *et al* (2006) comment that in England and Australia there have been recent landmark reports - Hall and Ellimann (2003) and Oberklaid (2000) - which have questioned surveillance/screening efficiency and the scope of health supervision from an epidemiological standpoint. These reports have led to changes to a more targeted and less comprehensive programme. It is this shift towards a new ideology of which preventive health services best meet the needs of children,

and what level of services are merited by children, that is the subject of this thesis.

0.2 The research problem

Since 1989 there have been recent major national changes in English national policy concerning preventive community health services for children. These changes originated from a working party set up by the Royal College of Paediatricians which proposed a national programme of children's preventive health services. This programme, which has been revised at frequent intervals, has been published in a series of reports (Hall and Elliman 2003, Hall 1996, Hall 1991, Hall 1989a). The recommendations of the latest 'Hall report' have been included virtually wholesale in the National Service Framework for Children, Families and Maternity Services (DH 2004a).

The main consequence of these changes has been the move to a programme which is increasingly directed at children with the most complex health and social needs. Whereas in the first 'Hall report' frequent universal preventive health contacts at key developmental stages were recommended (Hall 1989a), in the fourth edition (Hall and Ellimann 2003) it was proposed for the first time that some contacts should be discretionary. This report suggested that after four months of age children's face-to-face contacts with a health visitor could be negotiated with parents according to need, rather than provided universally for all children. This has had the effect of targeting the preventive health visiting services, as well as the child health promotion programme (CHPP).

Despite this being a major change to a universal child welfare service there has been little examination of the process by which this significant policy change has come about. Why was the child health promotion programme (CHPP) established? What happened to make reform seem desirable? Which professional groups have led change and which professional groups

have resisted? What are the views of practitioners on the changes to national policy? Has local policy changed in line with national policy, and have grass-roots practitioners altered their child health promotion practice? There has been little assessment of the impact of the changes to the child health promotion programme (CHPP) on their wider preventive work with pre-school children, and the knock-on effect upon other health and child welfare agencies involved with this age group. While there has been extensive academic and professional comment on the revision of the national child health promotion programme, there has been little empirical research into how national policy has translated into practice at a local level.

0.3 The relationship of the study to theory and the conceptual framework used

This thesis relates primarily to the body of theoretical and conceptual literature concerning the rationale for providing either universal or targeted health services.

It is now well recognised that health status is highly dependent upon socio-economic and social factors (Marmot 2004), rather than being primarily related to intrinsic biological factors. Due to an increased emphasis in English policy upon targeting health and social care services to those with the greatest need, there has been a decrease in services intended to improve health across the board (Wanless 2004). It has been recognised that there is a social gradient of health, and that universal interventions can increase health inequalities (Kelly *et al* 2007). (This argument is presented in more depth in section 2.4.5.) It is the growing recognition of these socio-economic determinants of health that has led to a shift in some areas of policy with a new impetus to direct services at those experiencing the greatest societal disadvantage, and hence the poorest health status.
The political relationship between universal and targeted services is the key theme underlying this thesis. This relationship will be discussed in the

literature review and is explored in the original empirical research study. In the conclusion, the relevant policy issues will be discussed in relation to the research findings and the contribution to new knowledge delineated. Although these debates play a seminal part in the structure of the thesis, changes in British policy on child health preventive services will also be discussed in terms of the wider context of social policy implementation. The reasons for this are given below and expanded further in section 0.3 which explains the policy process framework which structures this theoretical examination of the implementation of reformed child health promotion policy.

0.3.1 The policy process

The policy process approach has been chosen because it provides an exploratory and contextualised view of the change to this specific health policy. By means of this approach the change to policy can be seen from the broadest perspective, not beginning from a narrow or reductive standpoint. Instead the factors which have influenced policy change are traced through the literature review (chapters 1 and 2) then discussed in the light of the empirical study findings. This is line with the recognition within social policy research that policy frequently does not result from a fully 'intended' course of action, but is the unintended result of many different decisions made over time (Buse, Mays and Walt 2005). Therefore in this thesis many of the influences upon this specific health policy (the post-1989 reform of preventive health services for pre-school children) are described in broad terms, such as the relationship of the child and family to the state, state attitudes to health promotion and changing views on preventive health services.

Green and Thorogood (1998) have drawn up a policy process framework, which can be used to provide a structure for this examination of the origins and development of preventive health services for children.

Green and Thorogood's (1998) policy process framework

1. Setting the agenda- how some social problems come to the fore of government and public attention and become the objects of policy making
2. Formation- how possible responses to these problems are identified and which groups in society have a legitimate role in forwarding solutions
3. Implementation- how policy initiatives are decided upon and responses by policy makers are put into practice at different levels
4. Evaluation- how the outcomes of policy are evaluated, whether it meets its implicit objectives and what unintended impacts it has had and upon whom

Below is given a brief indication of how this policy process framework maps onto the study of the origins and development of preventive health services for young children. The stages of the framework correspond to the chapters of this thesis.

0.3.1.1 Setting the agenda

Two areas fall under this heading. The first question is how the normative health needs of children came to be identified as a 'social problem' with the result that universal health surveillance for children became part of national health provision. Secondly, the process by which the established system of universal health surveillance for children began to be seen as flawed and no longer relevant to the needs of children will be examined in detail. These issues are examined in Chapters 1 and 2. A thematic approach is used to identify the principal drivers for change, and key events in the development of children's preventive health services. The first chapter is concerned with the origins of both preventive health services for children, and health visiting as the profession providing these services, and their development to 1989. Chapter 2 looks at policy and health visiting practice from 1989 to 2008.

0.3.1.2 Formulation of policy

The development of child health promotion policy has been incremental with a variety of influences shaping the provision of services. The roles of the various professionals groups (both those who played an active role in putting forward solutions and determining the shape of preventive health services for children and those more passively involved in the process) are key to understanding how policy has developed. The ideology of evidence-based medicine has been influential in terms defining problems with existing services and in supporting changes to the CHP programme. Different uses have been made of this currently dominant ideology by professional groups to support or deter change. The ideas behind the formulation of child health promotion policy are introduced in Chapter 2, and discussed in more detail in the light of the research findings in Chapter 7.

0.3.1.3 Implementation

The empirical research project will explore the extent of implementation of the national CHP policy, indicating to what extent changes to local policy and practice have been enacted. Both the survey of health visitors' views and the nested interview study will explore barriers to implementation and the part played by local structural organisation and professionals 'on the ground' in determining the extent to which national policy is rolled out. Chapter 3 describes the research methodology. The findings from Phase I of the study (survey findings) are presented in Chapter 4, and those from Phase II (interview study findings) in Chapters 5 and 6.

0.3.1.4 Evaluation

In both the literature review and the empirical research project, consideration will be made of the process of evaluation of preventive services for children, the methods used to evaluate them, why these methods have been used and which groups are involved in evaluation. Both the intended and unintended

impacts of service reform will be discussed, including the effects upon service providers and service users.

It is not the aim of the thesis to make an evaluation of child health promotion policy. Instead the aim is to understand how children's preventive health services have developed and the process by which recent major policy changes have come about. Presenting the views of health visitors is in itself a form of evaluation, as they have lived experience of delivering the reformed programme. Their views raise issues which indicate which areas of the programme are meeting the needs of children, and which fail to do so. This embodies an alternative process of evaluation by which the views of practitioners are taken into account, a preliminary step in taking seriously the services offered to well-children, and placing value on the skills and experience of those who provide these services.

If an evaluation of the policy was being carried out it would involve a larger scale research project, taking an approach which would provide evidence based upon methodologies such as a randomised controlled trial. It would also involve seeking the opinions of a wider group of stakeholders, such as other professionals who deliver the programme, other agencies involved in child welfare such as Children's Centre workers and Voluntary groups. It is suggested that such an evaluation is long overdue and merited by the importance of this service to the health of children. Some of the reasons why this has not been done are discussed in Chapter 7, as are future potential developments in child health promotion and health visiting.

0.4 Research aims

The aims of this research are:

1 To chart the origins and development of preventive health services for children.

2 To examine the extent to which post-1989 national policy changes to children's preventive health services, in particular increased targeting, are reflected in local policy and practice.
3 To explore the views of health visitors on the effects of increased targeting of the child health promotion programme on their practice.

After tracking the emergence of the practice of routine child health surveillance and the changes in ideology which have influenced the provision of a programme of preventive health care for children, an empirical research project was carried out. This explored the effects of national CHPP reform, particularly the move away from a universal to a targeted health visiting service, on local policy and health visitors' practice. This was done by means of a national survey and a nested interview study.

0.5 My place vis-à-vis the research

My motivation to carry out this piece of research primarily came from my own experiences as a health visitor from 1996-2004. During this period many changes were made to the programme at a local level, mainly reducing the amount of routine contacts made by health visitors. Health visitors were told of the changes by the then director of public health who explained the evidence-based argument (i.e. that only procedures based upon evidence could justifiably be carried out), but who also added that the large number of referrals for identified health needs made by health visitors were frankly unaffordable. As a newly qualified health visitor it struck me as extraordinary that I was being told by a doctor what level of service to provide, and, even more extraordinary, that the disparity between level of need and the availability of services to meet those needs was so easily dismissed. Not seeing families so regularly would inevitably reduce demands upon secondary services, but what would be the effects upon children who had needs for those services?

During this information-giving session it also did not escape my attention that pre-school contacts provided by GPs were more likely to be well supported by evidence, where none of the health visiting interventions were. This was superficially logical (as procedures carried out by GPs are generally more overtly clinical and hence easier to support by scientific research evidence[2]) but also did beg the question about how much research had been carried out into health visiting interventions. Despite concerns expressed by health visitors at the meeting, changes did come about over the next few years. First of all the 3 ½ year check was discontinued[3], then all contacts after one year became discretionary.

My own personal practice was relatively little affected by the changes as I worked in an area of high need, where additional health visiting had been bought in by Sure Start. However, I was aware of wider concerns nationally about the 'paring down' of the service, and my commitment to investigating further was sealed when a reception teacher expressed concerns to me about the rising levels of undiagnosed physical and mental health needs in children starting school. She felt that children were presenting with problems (behavioural problems and undiagnosed conditions) which previously would have been picked up at the 3 ½ year review. She had encountered a child whose autism had not been identified in pre-school education, despite his behaviour being such that he continually disrupted the class. His parents were unaware of any concerns and had not sought help.

Thus my motivation in starting this project was partly a 'Joan of Arc' like desire to expose the iniquities of the system. During the course of this lengthy project much has changed in policy and practice, culminating in the publication of a revised Child Health Promotion Programme in April 2008,

[2] For instance the physical examination of the baby at 6-8 weeks of age.
[3] This was originally a pre-school examination carried out by the doctor, but had progressively become the work of the health visitor.

which goes some way to redressing the problems of the first. What has increasingly engaged my attention in exploring this topic has been the way in which a policy comes into being, and how it is modified in practice. I began to see the CHPP policy not just in isolation, but as an example of intervention provided by nurses which has been the subject of policy change. Studying this phenomenon has been highly revelatory of the forces that come into play when an attempt is made to change nurses' professional practice via policy. While being a health visitor was important in enabling me to see the questions raised by the CHPP reforms, in the following account the intention is not to take a blindly partisan approach, but to present a contextualised and nuanced picture of the CHPP, giving an understanding of its place in the history and current practice of preventive children's health services.

Chapter 1

A thematic account of the origins and pre-1989 development of preventive health services for children

This chapter is concerned with the way in which the health needs of well-children first came to the attention of the government, and became the object of policy making. It describes how different solutions to the 'problem' of maintaining and improving well-children's health were proposed at different times, according to which political and cultural ideas were in ascendancy, and the ability of different groups to influence the governmental policy-making process. Rein (1976) has suggested that 'policy paradigms', or models of how the world operates, dictate which policy solutions are successful in being adopted and allowed to bring about change. Policy paradigms consist of a 'curious mixture of psychological assumptions, scientific concepts, value commitments, social aspirations, personal beliefs and administrative constraints' (Rein 1976, p103). It will be apparent in the following account that all these factors have influenced the development, direction and re-direction of preventive pre-school health services throughout their history. In order to change policy, paradigms must be challenged by an alternative view of the world which appears to fit current problems better (Allsop 1995).

In this account I will discuss the dominant policy paradigms which have influenced contemporary children's health services, with particular reference to the relationship between universal and targeted preventive services. Titmuss remarked that welfare services can only be understood in the context of the times that formed them (Titmuss 1938); this preliminary analysis serves to demonstrate the influence of changing times, and provides a platform from which the late 20th century reforms of child health

surveillance can be viewed. As well as discussing the nature of the health services available to children, the account will also address the health workers who provide them. I shall structure the following account by examining significant events or policy initiatives in a chronological order.

These key events are;

- 1867 The employment of the first 'health visitor'
- 1904 The Report of the Interdepartmental Enquiry on Physical Deterioration
- 1907 The Notification of Births Act
- 1948 The National Health Service Act
- 1956 The Jameson Report
- 1976 The Court Report

Each key event will illustrate a particular theme which has had a lasting effect upon the way in which children's services have developed. Although the chapter is arranged chronologically, within each section I shall discuss this event in the context of its wider significance as part of the development of well-children's health services. This means that each section ranges over the pre-1989 time period, and sometimes the same event is looked at from a different angle in subsequent sections. This thematic approach permits an in-depth exploration of the political and social background to the development of health services for well-children, which acknowledges the many disparate factors which drive policy formation.

Copious literature exists about the origins and development of community child health services from a variety of sources. As an initial step, searches were made of databases, such as Ovid, Medline, Cinnahl, British Nursing Index, Assia, Embase and Psychlit (looking at literature from the start of each data base to 2008), using the terms child health surveillance and child health

promotion. However, because commentators on services for children, and related themes such as surveillance and monitoring, predominantly come form a medical background, this was not sufficient to present an analytical account. Other areas of study particularly relating to the development of children's community health services are commentaries on the Welfare State, studies of childhood and child development, and social histories of medicine and the nursing profession. Once initial subject areas had been established, more diverse sources were obtained by searching bibliographies. Among the literature used to produce the following thematic account were contemporary writings, government policy documents and interpretive accounts of contemporary and past events.

1.1 Public health and the origins of children's preventive health services

Key event- 1867 the employment of the first 'health visitor'

It is commonly agreed that preventive health services for children had their roots in the Victorian public health movement (Court 1976, Polnay 1996 and Billingham, Morrell and Billingham 1996). In the Industrial Revolution people flooded into the cities to find work, partly due to the attraction of the growing cities, and partly because of displacement of people from the countryside by landlords (Ashton and Seymour 1988). This put pressure on housing, leading to the development of slums, and also upon sanitation, leading to squalor and hence disease. The great cholera epidemics of 1832 and 1848 affected the middle as well as the working classes, and there was an increasing sense that to protect the health of all, the health of the working classes needed to be monitored and improved. As a result of his influential study into the conditions of working class life, Chadwick (1842) argued that money spent on sanitation would result in fewer demands on poor relief and the addition of at least 13 years to the lives of working people, demonstrating that economic as well as humanitarian factors played a part in reform.

Increased awareness of the unhygienic conditions in which the working classes were living and working, with the consequent risk of infectious disease, meant that both the public and the government were ready to address environmental conditions. Medical knowledge at the time was such that the causes of disease were not understood and the only way to stop the high death rate in the overcrowded cities was to improve public health, initially by engineering means. The government progressively began to pass legislation designed to improve public health. Such legislation was initially permissive (for instance the 1866 Sanitary Act which made local authorities responsible for the purity of the water supply), but increasingly the government became more ready to enforce legislation to protect health (Robinson 1982). Some opposition to the new public health measures came from the Conservative press who argued that they represented unnecessary intervention in the life of the individual and affected the operation of market forces, but rising mortality rates from infectious disease forced the government to take a more managerial stance (Porter 1997). The slow rate of change suggests the State engaged reluctantly in such 'social engineering' and was only prepared to intervene in the context of the acute public health problems of the time (Dingwall and Eekelaar 1988).

Legislation to improve the health of children was among the earliest to be passed. The 1833 Factory Act introduced a statutory medical examination for the under 16s to ensure they were fit to work, and the Royal Commission of 1861 examined the effect of work upon children's health. While older accounts of this period emphasise legislative progress and increased State obligation, particularly towards children, more recent analytical accounts propose a more complex set of causes and consequences (Hendrick 1997). One of the major drivers in the new involvement of the State in public health was the need to ensure adequate numbers of British workers (Davin 1978). The rise of trading competitors, such as Germany, Japan and the USA, had

raised concerns about Britain's decline as an international power. In addition the growing power of the working class, linked with the formation of the Labour party, posed a series of threats to the established political and economic order (Lloyd 1986). Hamlin (2002) claims that the response to epidemic diseases by governments in developed countries is almost invariably motivated and shaped by the need to preserve the commercial, cultural and military welfare of the state, rather than a sense of obligation for the health of the individual.

Preventive health services for children did not originate from government action but from voluntary work in the regions. It is customary to date the origins of organised community health services from the appointment of the first health visitor in Manchester in the 1860s (Court 1976, Dingwall 1977, Polnay 1996). Chadwick's idea that sanitation was the primary means by which infectious disease could be controlled, inspired the formation of many voluntary societies in the industrial cities with the aim of promulgating public health measures (Lamb 1977). The all-male Manchester and Salford Sanitary Association was one of these voluntary organisations. In 1852 a ladies' branch was established, which conceived of employing a respectable local working woman to go among her neighbours and spread ideas about cleanliness and sanitation (Robinson 1982). This 'health visitor' was to give advice and teach by practical example, for instance in caring for the sick, keeping the home clean and caring for children (Jameson 1956), as well as advocating hygiene (she could supply lime, whitewash brushes and carbolic soap) (Billingham, Morrell and Billingham 1996). While some authors have questioned how innovative a development this really was[4], the Manchester

[4] Dingwall and Eekelaar (1988) stress the continuity of the initiative, founded as it was upon a predominantly rural tradition of charitable visiting. The practice of visiting the poor at home with the aim of improving their physical and moral well being was commonly carried out by many middle-class women on an informal Voluntary basis (Lewis 1984). Such philanthropic visiting was an accepted activity for middle-class women as it did not challenge the male world of paid work (Davies 1988).

appointment represented a new direction for home visiting in that the heath visitor was a member of the class she was employed to visit, she was paid, worked under an organised governing body, and had a remit of what work to do.

From the 1870s the most pressing environmental problems were beginning to be brought under control (Ashton and Seymour 1988). By 1900 typhus fever had practically died out because of less overcrowding, and there was a great reduction in typhoid fever due to improvements in sanitation and the provision of a clean water supply (Frazer 1950). Progress in medical research, specifically the development of germ theory, meant that causes of disease were better understood, with the result that widespread public health measures were no longer needed to tackle the spread of infectious diseases (Ashton and Seymour 1988). The health of all strata of the population was no longer seen as inseparable. As a consequence of this, the environmental approach to public health, which had dominated since the 19th century, was replaced by a more medical and individualised approach to the protection and improvement of health (Lloyd 1986). Public health never again achieved the significance it had in the 19th century, and environmental influences on health were no longer seen as of first importance until the late 20th century and the emergence of the new public health (Ashton and Seymour 1988).

Despite the decline in public health medicine, health visiting continued to expand on a regional basis under the jurisdiction of medical officers of health. Health visiting was a strategy developed at a local level, which was quickly adopted at a national level. At the end of the 19th century health visitors began to be employed by local authorities rather than voluntary organisations (Lewis 1984). In addition to home visiting by health visitors, local authorities provided baby clinics, where babies and young children could be brought for weighing and health advice. The provision of clinic services marked the increasing involvement of the State in medical and social welfare (Ashton

and Seymour 1988), but continued to separate the health of children and childbearing women from any wider concept of national healthcare. At the turn of the century the pattern of British children's preventive health provision was established, with home visiting as the 'bedrock of the system' (Lewis 1980, p105). Health visiting was beginning to make the transition from a privately funded and organised service to a State scheme (Dingwall 1977).

1.2 The influence of changing views of childhood

Key event- the 1904 Report of the Interdepartmental Enquiry on Physical Deterioration

The more medical and individualised approach to the health of the population manifested itself in a new direction for children's services. A major concern for medical officers of health was the infant mortality rate, which in contemporary informed opinion was strongly associated with the way children were cared for in the home. Infant death statistics began to be collected and published in the 1870s, and concern was expressed about the rising infant mortality rates (146 per 1000 live births in 1876, and 156 per 1000 live births in 1897). This fuelled fears that the working classes were not replacing themselves in sufficient numbers to maintain the workforce (Hendrick 1997). In 1906 the Chief Medical Officer to the Board of Education argued that infant mortality was 'a question of motherhood' and that the most influential causal factors were domestic dirt and ignorance of infant care. In doing this he ignored available statistical evidence which showed that high infant mortality was a problem of inner-city areas where there was bad sanitation (Lewis 1984). The idea that high mortality and morbidity among working class children was a result of feckless mothering was one that dominated the development of children's services for the next decade (Davin 1978).

But why had the health of well children risen to the forefront of public and governmental attention? A dominant factor in shaping health services for children is the attitudes prevalent within society towards and about children (Court 1976). Attitudes to children changed dramatically over the Victorian period. In the mid 19th century there was an increase in what Dingwall (1982) has termed an evangelical feeling about children. Such issues as the slave trade and cruelty to animals had attracted much campaigning fervour but had now achieved significant gains, providing an opportunity for another cause to be taken up. Novelists earlier in the century had drawn attention to working conditions in factories in the Northern industrial cities (e.g. Mrs. Gaskell's 'North and South'). The hugely popular Dickens had highlighted the plight of children in institutions and on the streets ('Nicholas Nickleby and 'Oliver Twist'). There was popular moral outrage about the way children were treated, linked to a prevalent view that industrial society caused moral degeneration in both the employer and employed (Dingwall and Eekelaar 1988). Whereas adults might be hardened and irredeemable, children were seen as 'unformed' and able to change (Cunningham 1995). From 1860 the Christian Revivalist movement focused on the 'rescue' of children, providing refuges and 'ragged schools' to feed children and protect them from the dangers of the streets. Child rescue activities were given an organisational context by the creation of several children's societies (Dr Barnado's in 1866, the National Children's Home in 1869 and the National Society for the Prevention of Cruelty to Children in 1884) (Parker 1995).

This evangelical feeling about poor children translated into government legislation to alter their working and living conditions. At the beginning of the 19th century child labour was considered acceptable, but progressively children's work (first chimney sweeping, then mill work and finally all factory work (Hendrick 1997)) came to be seen as an unacceptable and were legislated against. By 1911 less than a fifth of children under 14 were employed. The decline in child labour was matched by an increase in child

education. Few working-class children were in full time education in the 1850s, but the 1870 Education Act introduced compulsory elementary education for all. Over the rest of the century the school leaving age gradually increased for both boys and girls (from 10 years of age in 1870 to 12 years of age in 1899), extending the period of dependent childhood. In addition the first acts to protect children from exploitation by others were passed in the late 19th century. The 1889 Prevention of Cruelty to Children Act, which aimed to protect children within their own homes, was a landmark as for the first time children were accorded rights as distinct from those of their parents (Hendrick 1997). During this period children began to be seen as a group with a distinctly different identity from adults, who required added protection from the risks and responsibilities of adulthood.

Despite late 19th century concerns about the health needs of working-class children, there were as yet no health services provided to meet them. Since becoming a unified and self-regulated profession in 1858 (under the Medical Registration Act), the medical profession largely operated on a fee-for-service basis (Lupton, North and Khan 2001), with patients who could not pay being reliant on obtaining treatment on a charitable basis. Lewis (1984) has argued that early 20th century state welfare provision did little to alleviate the position of working-class wives (and presumably their children) because it assumed the existence of a bourgeois model of family life with a male wage sufficient to meet family needs. Despite strong evidence to the contrary, it was assumed that a working man would be able to pay for private medical care for his wife and children. However, despite governmental reluctance to usurp the parental role (Court 1976), it was becoming increasingly apparent that steps needed to be taken with regard to the health of working-class children. A side effect of compulsory schooling was that it allowed children of the same age to be observed together as a group (Parker 1995). This made school aged children collectively visible for the first time and exposed

previously unimagined levels of malnutrition and physical defects (Court 1976).

What brought home most strongly to the public and the government the extent of malnutrition and disease among working-class children was the highly-publicised scandal over army recruitment for the Boer war campaign. The revelation that large numbers of recruits were simply not fit enough to join the army (as many as two out of three young men were unfit in some areas) led to huge public outcry about the impact of what was described as 'physical degeneracy' (Court 1976). The implications for the ability of the country to maintain its manufacturing base and defend its empire were made explicit in newspaper commentaries of the time (Hendrick 1997). Hendrick (2003) has described the emergence of this new popular construction of childhood as due to the pre-eminent idea that a British child was a 'child of the nation'. This construction linked a nationalistic desire to ensure sufficient national strength in order to maintain the supremacy of the British Empire, with eugenicist concerns about children's fitness and the quality of the national 'stock'.

In response to the national furore, the government ordered an Interdepartmental Enquiry on Physical Deterioration, which reported in 1904. The recommendations of this enquiry were mainly of a health promotion nature, making individualistic recommendations about diet, exercise, alcohol and smoking (uncannily similar to the recommendations of the 1992 'Health of the Nation' report (Polnay 1996)) while ignoring more politically contentious causes of ill health such as wages, housing and terms of employment (Dwork 1986). Although structural changes to improve the health of working-class children would not be countenanced, this enquiry was influential in consolidating the need for preventive services for children, and for ensuring continued financial investment. As a consequence of the enquiry the school health service was established, which has been described as the

forerunner of universal child health surveillance for children (Polnay 1996). The dominant tendency was now for the State to take collectivist action, making use of public health workers rather than relying on charitable action (Dingwall 1977).

This new concern about the health of the British child provided an opportunity for the medical profession to establish its involvement in preventive health services for pre-school children[5]. Not only did doctors have specialised knowledge about child health and development, but they could act as an agent of the State in protecting children. It became customary for the health and development of well-babies to be monitored by a doctor in the newly established local authority community clinics, which were run by health visitors and volunteers[6]. Ross (1993) quotes a clinic doctor as saying in 1909 that 'even the healthiest baby should have medical supervision', an idea which persisted unquestioned until the 1980s. Free medical treatment was not provided at clinics, despite the high cost of medical care and uneven provision of GPs across the country. The Insurance Act of 1911 introduced free medical care for working men, but this was not extended to women and children. Debate took place as to whether medical services should be provided for the poorest families but 'the use of public funds was resisted as removing a basic parental responsibility, not least by those defending private medical interest' (Court 1976, p57).

National concern about the quality and quantity of British working-class youth never again reached the heights of the Boer war campaign, but has

[5] It is important to remember that at this time medicine was also a young profession, which had only recently succeeded in separating untrained practitioners from the certified and self-regulated (Walby and Greenwell 1994). In the early 20th century medicine was seeking to establish its place and the central importance of its role within the developing health services.

[6] These developed from the infant feeding depots which were established in Britain, often by volunteers, in the late 19th century. This followed the example of countries such as France, Canada, and the Netherlands, who were also concerned about poor maternal and child health. In Britain feeding depots did not achieve widespread adoption, as they did not fit in with the 'advice without dole' model which was later incorporated into legislation (Court 1976).

reappeared sporadically at times of national threat. Both world wars were characterised by resurgent pro-natalism (Riley 1983). Even though in the 1930s infant mortality rates in the some areas of Scotland again rose, without the pressing need for workers and soldiers and in a political climate where there was less fear of the working classes rebelling, an increased mortality rate did not have the same resonance with the government as it did in the 1890s (Lewis 1980). Other influences led to a fall in the average number of children per family and a general improvement in child health, which meant that the subject was not of pressing governmental concern (Robinson 1982). At the beginning of the 20th century the structure of preventive services for children was established, and the ideology of making special provision for maintaining children's health had become an unchallenged part of the emerging welfare state.

1.3 The rise of health visiting

Key event- 1907 Notification of Births Act

Throughout this thesis it will be apparent that the origins and development of preventive health services for children and the health visiting service are intimately entwined. This has meant that developments in health visiting have served to shape and dictate the form of children's preventive health services. In a statement which is equally applicable to health services for well-children, Elkan *et al* (2000a) suggest that the history of health visiting encapsulates many of the debates in modern health policy, illustrating tensions between acute and preventive services, hospital and community, universal versus targeted services and the relationship between individual privacy and the role of the State. In the following account of the rise of health visiting I will concentrate on those areas which have had most consequences for health visiting in the late 20th and 21st centuries. These are the struggle to establish health visiting as a profession, attempts to define an area of unique health visiting practice, the influence of gender upon the development of health visiting, and the relationship between health visiting and nursing.

While the first health visitor was a working woman, health visiting very quickly became an occupation for the educated middle-class lady. When they became employees of the local authority health visitors ceased to be a catholic assortment of voluntary visitors, paid local women and working-class women's self-help groups, and no longer originated from organisations formed and run locally by women (Davies 1988). Instead of the respectable working-class missioners of the Manchester and Salford society, educated women were employed who incorporated home visiting into a wider public health inspection role. Early 20th century health visitors could be a doctor, a nurse, a midwife or someone with experience of working as a health visitor (Lamb 1977). Lloyd (1986) has shown how the development of the health visiting role was profoundly affected by the relationship between medical officers of health (MOHs) and their health visiting workforce. MOHs undoubtedly played a role in focusing health visiting on home visiting of mothers and young children, because of their mandate to address infant mortality rates, and their reliance on health visitors' ability to monitor child health within the home. While health visiting originated outside the medical division of labour, it increasingly became defined as complementary to, rather than independent of, medical dominance (Lloyd 1986).

In addressing the problem of continuing high infant mortality rates local medical officers of health looked to health visitors to influence mothers to make changes in home child care. Davies (1988) has described MOHs as being in an insecure position because of uncertain tenure and variable levels of local interest in public health, which contributed to an appreciation of health visitors as co-workers. In 1901 the MOH in Huddersfield, launched an attack on the local infant mortality rate. This consisted of organised visiting of all newborn babies in the working and lower middle-class areas, to give help and guidance on infant management. When it was realised that many babies were dying before the health visitor's first home visit, notification of birth to

the medical officer of health was made compulsory by the Huddersfield Corporation Act (1906). The National Conference on Infant Mortality in the same year found that Huddersfield had the most fully developed system of 'domiciliary visitation for the promotion of infant welfare' (quoted in Lamb 1977). This success led to the provincial initiative of birth notification being taken up nationally, and by 1915 registration of all births became compulsory under the Notification of Births (Extension) Act.

This Act served to further embed health visitors in the public health provision made for mothers and children. It was a key event for the emergent profession of health visiting as it signalled government recognition of its central role in providing services for parturient mothers and children (Maxwell 1997). The introduction of legislation for the purpose of providing health visiting services illustrates the central importance of health visitors in the MOHs' strategies for public health, as well as the willingness of the government to incorporate health visiting into social policy. Ross (1993) has pointed out how the increased bureaucracy and formality in recording births made possible the subsequent elaborate system of home visits to infants and mothers in non middle-class households. The assimilation of health visiting was complete when in 1918 the government agreed by the Maternity and Child Welfare Act to make provision to reimburse boroughs which employed health visitors and midwives. Despite many changes in the health visiting role, and numbers of health visitors never reaching recommended levels, health visiting continued to hold its place at the forefront of child welfare, and retained its status as the lead agency until the successful challenge of social work in the 1950s (Robinson 1982).

Many health visitors in the early 20th century held joint roles in health visiting and sanitary inspection. Factory Acts which required the inspection of workers, led to a role for women to inspect factories which employed women workers. Davies (1988, 1997) has described how radical London-based

health visitors fought to maintain the dual role, but lost the more lucrative wider role to (male) public health inspectors who went on to develop into environmental health officers. This demonstrates, for the first time, Perry's (1993) axiom that nurses rarely get first bite of the cherry when defining their role. Davies (1988) has argued that health visiting's mistake was to value equally the home visiting and the sanitary inspection roles, and to attempt to claim value for the 'womanly' qualities that were needed for home visiting. When health visitors could not hang onto both roles, they were channelled into the lower-paid, home-focused health visiting role, and could not avoid being excluded from the male-dominated sanitary inspection work. MOHs were particularly vocal in claiming that, as women, health visitors were more naturally suited to operate as a 'mother's friend' in the home setting, rather than to take on the masculine role of being an 'inspector' (Dingwall, Rafferty and Webster 1988). It is not surprising to read that, in practice, many health visitors continued to write letters about housing and continued to engage themselves in the widest social and environmental determinants of health (Davies 1997).

The loss of the diverse and complex joint role, and the new concentration on the narrower family and child-centred field, was compounded by health visiting becoming solely an occupation for nurses. Dingwall, Rafferty and Webster (1988) describe the process by which health visiting was 'captured' as a branch of nursing as being imperfectly understood. However, it probably relates to a demand for some health visitors (particularly those acting as school nurses) to carry out a clinical role, and to a temporary over-supply of trained nurses. From the 1920s health visiting became increasingly a nursing profession, and developed a university-based training and a nursing-based examination structure. This served to create an identifiable profession for women, with certification as an exclusionary occupational closure strategy (Witz 1992). However it divorced the profession from its radical, provincial origins, and further linked it into the nurse/doctor model of subservience and

power (Davies 1995). Dingwall (1977) suggests this led to a change in the nature of health visitors, as nursing then demanded obedience, recognition of the pre-eminence of doctors and a commitment to a medical rather than an environmental model of health. A midwifery qualification became a requirement for entry to health visiting training which meant that health visiting was enshrined as a female profession. It was only in the 1970s, as part of the sex equality movement, that the legal restrictions to men being either midwives or health visitors were removed (Dingwall 1979).

The final point to consider here is the continuing relationship between health visiting and nursing. Health visiting was fortunate in achieving early central importance as the main agency in the battle against infant mortality, which gave kudos to the incipient profession. The superior womanly qualities that health visitors were supposed to make use of when visiting the home, such as tact and friendliness, were highly valued, but as natural attributes of women, rather than as qualities that needed to be acquired or rewarded with high pay (Davies 1988). Both nursing and health visiting are increasingly recognised as occupations defined and shaped by gender (Perry 1993, Davies 1995, Baer 1997, Miers 2000). Initially health visiting appeared less adversely affected by being an exclusively female occupation, than nursing. From its early days health visiting contrived to establish a more equal relationship with, and more autonomy from, doctors, as a result of its non-nursing origins and the less secure position of MOHs in comparison with other doctors. Although the assimilation into nursing could potentially have damaged the high standing of health visiting, the profession retained valuable advantages, such as a university-based training and better conditions of employment, which contributed to health visiting being seen as a relatively high status occupation for women, and definitely a cut above nursing.

Health visiting remained in professional ascendency over nursing until the late 20th century, when the pursuit of high-level clinical skills became the route to higher status and pay (Baer 1997). The attempt to establish a 'new nursing' in the 1980s in which patient care was highly valued as a skilled activity ultimately failed (Luker 1997). Factors such as the reduction in junior doctors working hours, and the drive for cost-effectiveness, meant that more roles were created whereby specialist clinical nurses took over tasks previously carried out by junior doctors (Doyal, Dowling and Cameron 1998, Nottingham and O'Neill 2000, Denny 2003). Hallett (2007) highlights the lure of becoming 'super-technicians' and sharing the technocratic knowledge of doctors, for nurses who had lacked success in gaining power based on their own core nursing knowledge-base. As a consequence of the elite taking on high level tasks and leadership roles, the care of patients is increasingly left to an unqualified, non-professional and peripheral workforce, which is also disproportionately female and non-white (Robinson 1992)[7]. This has led to further demotion of the status of 'care' in relation to 'cure'[8], and more problems for health visitors, who have always differed from senior hospital nurses in being 'socio-medical' practitioners rather than managers or clinical specialists, in justifying their status and role.

1.4 The birth of the NHS

Key event- 1948 National Health Service Act

In 1948 it was decided by democratic mandate that the UK health care system would become a centrally controlled bureaucratic system. This meant that the State took over the role of determining health policy and became

[7] Corby and Mathieson (1997) agree that numbers of support workers in the NHS are increasing. The advantages of such workers are that they are generally less securely employed, lower paid and provide a more flexible workforce, which can be expanded and reduced according to demand.

[8] The relationship between caring, as women's work, and nursing is too large a subject to discuss here. Some attempts have been made to defend nurses' professional caring role, notably Tudor Hart and Dieppe (1996) who argue that the quality of nursing is measurable and affects mortality in hospitals. Perry comments: 'The old problem of powerlessness in nursing cannot be cured by assertiveness training, quality management styles or even an academic education; nurses' lack of authority is not the fault of passive individuals, but a system of healthcare which undervalues caring as non-scientific work' (Perry 1993, p47).

involved in the distribution of health care. Access to health services was to be determined according to equality criteria, and the State took control of allocating resources and ordering priorities (Allsop 1995). For the first time everyone was entitled to free care from a GP or in a hospital provided by the State. The NHS was based on an 'institutional redistributive' model of healthcare provision (Titmuss 1958), by which the State redistributed benefits through the tax system. Dingwall (1977) has described this model of providing health services which are free to all at the point of the delivery regardless of means or circumstances, as being collectivist in character. In other words the aim at the foundation of the NHS was to improve the life of the population as a whole rather than to improve the life of individuals as individuals.

Despite its status as an iconic British State institution, it is important to recognise that the NHS has always been a mixed public-private enterprise. Under the new organisation general practice (GPs), dentistry, ophthalmic services, and high-street pharmacy all remained as private businesses (Salter 1995). Rather than fundamentally altering the health services on offer, the NHS imposed upon the existing patchwork of health care provision (hospitals owned by voluntary bodies and local authorities, and GP services) a new neat administrative structure (Klein 2001). This pragmatic approach reflects the attitude of the civil servants who brokered the agreements with powerful bodies such as hospital doctors and GPs. In such negotiations the aim was to achieve a compromise which minimised the chances of continuing conflict (Klein 2001). In bringing into being the new NHS it was most important to win over the doctors, who had most to lose from the imposition of a State-funded rather than private system of healthcare. When in 1948 it seemed that the opposition of the British Medical Association was going to prevent the launch of the NHS, Bevan made the concession that GPs could be paid on a capitation fee basis rather than be salaried employees of the new NHS (Allsop 1995).

Consultation about the structure and administration of the new NHS was carried out with the voluntary hospitals, local authorities, and most of all doctors, but did not engage other parties who might have an interest in the development of a nationalised system of health care. Among the excluded parties were the societies running the existing National Insurance system and non-medical health workers, such as nurses and support services (Klein 2001). In this way was established the right of the medical profession to be involved in the formation of health service policy and to take a central role in the planning and the running of the NHS. Conversely the principle was also established that other health workers were not legitimate actors with a claim to participate in negotiations. Klein (2001) has described the history of the NHS as a history of the relationship of the government of the day with the medical profession. Although nurses have always been by far the biggest single element in the NHS labour force, giving the majority of care to patients[9], they have barely figured in NHS policy making (Levitt, Wall and Appleby 1995). Beardshaw and Robinson (1990) comment;

> 'Traditionally, nursing practice and its organisation, management and future direction have been little discussed by policy makers outside nursing, despite the direct relevance of these subjects to the shape, quality and cost of health care as a whole. In an important sense, nursing issues have been marginal to debates that have shaped British health policy since 1948.' (Beardshaw and Robinson 1990, p5)

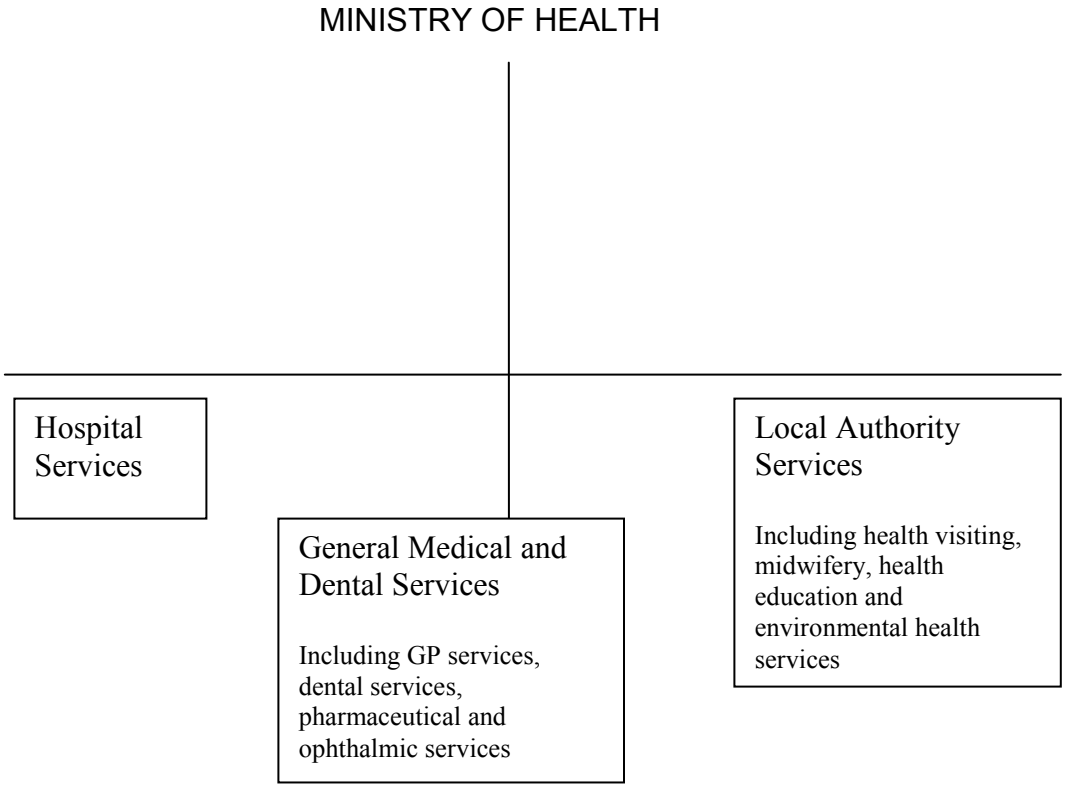
The new National Health Service structure brought some change and much continuity for children's preventive health services. Rather than being placed with the bulk of NHS services, maternity and welfare services continued to be provided by local authorities. It can be seen from figure 1.1 that, under the tripartite structure, hospital services, GP services and local authority health services each occupied different branches of the organisation. This meant that the health services that might be used by children were administered

[9] More than half of all NHS staff are nurses and nearly a quarter of all health service expenditure is directed at nursing (Beardshaw and Robinson (1990).

separately, creating a division between hospital and community services, community medical and nursing services, and acute care and prevention.

Figure 1.1
The structure of the 1948 National Health Service

(adapted from Baly 1995)



Under the new structure hospital services had most prestige, and the most generous funding. The NHS was created at a time of faith in scientific

rationalism, where few questioned the past achievements of medicine. Medicine had recently developed effective cures for some previously intractable diseases, and had performed an important role in creating new treatments and rehabilitation regimes in the Second World War (Klein 2001). Although the stated aims of the NHS included the prevention of ill health, in practice public health medicine was limited to the activities of medical officers of health (MOHs) in local authorities. The separation between the public health function and other medical care, put public health services in a weak position within the new NHS structure (Allsop 1995). Until 1974 MOHs remained responsible for public health and the coordination and delivery of community health services, but unlike in the 19th century, they could no longer respond to local public health needs, and had limited influence on health policy.

The NHS Act (1946) required every local authority to provide health visiting services for young children and their mothers, pregnant women and the sick. This widened the scope of health visiting work to include care and after-care. In the 1930s many health visitors had been engaged in a wider range of activities, including infectious disease nursing and tuberculosis control, but care of the sick had never been a statutory part of their work. Despite offering expanded opportunities in clinical care, in practice the 1948 Act served to consolidate health visitors' traditional role. By keeping health visiting firmly within the MOHs' domain, the tripartite structure ensured that health visitors remained wedded to the environmental model of health, long after trends in medicine had moved away from this approach (Lloyd 1986). White (1985) argues that the extent of health visitors' existing work gave little scope for taking on additional tasks. The requirement for local authorities to visit all newborn babies was delegated to health visitors, and, with double the recommend caseloads of under-fives, health visitors were forced to concentrate their efforts on babies and the follow-up of pre-school children (White 1985). Local authorities also had responsibility for immunisations,

which was discharged via health education and advice offered by clinical medical officers (CMOs) and health visitors.

Court (1976) makes the point that the reorganisation of services under the NHS vastly improved services for children, as previously these had been fragmented and of variable quality. Court (1976) considers the main flaw of the tripartite structure was that it created the illusion that primary healthcare for children could be split between prevention and cure, with separate services providing for each. This was because the GP contract did not explicitly cover preventive services and local authorities were debarred from giving treatment. Thus the local authority system of child welfare clinics worked alongside the curative system where GPs provided health care, but not preventive health services, for children on their lists. After 1948 virtually the entire population registered with a GP, meaning that GPs became more involved in providing advice and care to mothers and young children (White 1985). In the 1970s health visitors began to be 'attached' to GP practices, while retaining the lead role in routine child health surveillance (Robinson 1982, Lupton, North and Khan 2001). Unable to treat, or prescribe for, the patients of GPs, clinic doctors concentrated on health monitoring for the well-child (Royal College of General Practitioners 1983).

In 1974 the health service was again reorganised, following the recommendations of the Porritt Committee. The tripartite structure was increasingly seen as the source of many problems within the NHS, such as the lack of integration between services, the poor quality of services for the mentally handicapped and older people, and the lack of administrative control, particularly over the more powerful medical specialties who were able to commandeer the lion's share of available resources (Ham 2004). The 1974 restructure attempted to create a strong regional tier which would act to generate strategic priorities (Holliday 1995). As part of the reorganisation, community healthcare services were transferred from local government and

became part of the central NHS structure for the first time. Health visitors' statutory responsibility remained to visit mothers with young babies, and to monitor the health of young children (Allsop 1995), while responsibility for environmental health stayed with local government.

What was the effect of the long sojourn under local government management on health services for children? The role of the medical officer of health did not survive the reorganisation, and health visiting's survival is testimony to its success in establishing a role which could exist independently of this alliance (Boaden 1997). By 1974 community services were provided by community medical officers (CMOs) and health visitors, with GPs providing curative treatment. By virtue of their relative isolation under local authority control, health visitors retained greater freedom to carry out their work with relatively little outside management (Dingwall 1977). This played a large part in determining the development of health visiting, particularly in terms of the nature of the negotiated, low-key, non-authoritarian and largely unregulated involvement with clients (Dingwall 1982). Lupton, North and Khan (2001) have identified how, with a relatively flat hierarchy and working within the home, health visitors between 1948 and 1974 were far less open to scrutiny than hospital nurses, and possessed far greater autonomy. Once within the mainstream NHS they became subject to the increased managerial control that hospital nurses were experiencing, and came under pressure to adopt a more structured and authoritarian approach (Dingwall 1982). Increasingly health visitors were required to justify their practice in clinical health service terms, an activity to which they were unaccustomed.

1.5 State intervention in family life

Key event- the Jameson Report (1956)

Child health provision in the early 20th century focused extensively on instructing working-class mothers in how to care for their children. It is

recognised, primarily by feminist historians, that this placed an intolerable burden upon women, by increasing expectations of their behaviour as mothers without acknowledging the conditions under which they lived (Ross 1982, Lewis 1984, Dwork 1986). Without the provision of treatment, school medical inspection and the advice of health visitors became injunctions to 'make bricks without straw' (Lewis 1984). The huge political and social reforms of the period, such as universal education and legislation to end child labour, did not serve to ease women's lot. The 1870 Education Act not only deprived the family of children's earnings but also of informal care of younger children while the mother worked. With the introduction of school attendance officers, families who did not ensure their children went to school were fined (Lewis 1986). Policies were formulated on the basis of a family wage, but in many cases the wages received by men were inadequate to support a family. Although a consensus existed among policy makers and trade union officials that a woman's place was in the home - women workers were considered to pose a risk to male jobs and wages - in reality many households needed the woman's wage (Lewis 1986). Medical officers of health were in strong opposition to mothers working outside the home, seeing it as a major cause of morbidity and mortality (Ross 1982).

The increasing visibility of children in schools and clinics created opportunities for the child and its mothering to be displayed to authorities. The child's health ceased to be a family matter, but had become the concern of the State. This was accompanied by an expectation that the family must play a part by caring for the child in State approved ways. Rose (1990) proposes that in the early 20th century;

> 'The medical apparatus of public health extended its scrutiny to all children from birth, in the homes and in the schools…legal powers and statutory institutions provided a platform for the deployment of medico-hygienic norms and expertise, seeking to turn the school into a medical station and the home into a site of prophylaxis' (Rose 1990, p128).

Surveillance has been of particular interest to sociologists and historians because it is imposed upon the recipient. By contrast the impetus of the individual to seek medical help for a self-identified ailment is seen as much less politically and philosophically problematic. Foucault (1973, 1977) examined the social processes by which the individual becomes the object of State surveillance, scrutiny and control. 'The Birth of the Clinic' (Foucault 1973) was concerned with the social context of medical history, theory and practice, and revealed how social reforms were deeply related to problems of social order and control (Swingewood 2000). Surveillance, or what Foucault termed 'the clinical gaze' (Foucault 1973), introduced a new way of looking at individuals. By observing the bodies of sectors of the population (such as babies or school children), State-sanctioned specialists could judge their status, analyse their defects and monitor their functioning (Armstrong 1993). Threats to the body were no longer perceived as coming from the environment or inadequate sanitation, but from the relationships between people, for instance the mother and the child. As a result preventive medicine became concerned with the minutiae of social life (Armstrong 1993).

Examination has been made of the health visitor's role in the light of Foucault's work. Historically health visiting has been described as the first intrusion of the State into the private world of the family (Dingwall 1977). Studies of interaction between health visitors and clients have been made, using a Foucauldian framework, which demonstrate the interplay of power and the regulatory nature of the encounter (Lauritzen and Sachs 2001, Wilson 2001, Peckover 2002). Bloor and McIntosh (1990) describe how the monitoring of the well-being of children, accompanied by promotion of 'healthy lifestyles' is manifestly linked to the collection of evidence about the quality of childcare by observing the child and its home. These observations are used to promote and sustain behavioural change, but are also used to detect abuse and neglect. In this lies the ambiguity of health visiting, by which the health visitor is expected to establish a caring and supportive

relationship with the family, while being charged with the responsibility of monitoring the adequacy of parenting and identifying potential abuse (Bloor and McIntosh 1990). This ambiguity has also been noted by health visitors, but with more optimism that this ambiguity can be managed within the context of the health visitors' relationship with the family (Robinson 1982, Malone 2000, Wilson 2003)[10].

At its most extreme interpretation, health visiting can be seen as part of a process of 'social policing' by which the family is ever more tightly observed and regulated by an interlinking web of public agencies (Donzelot 1980). Dingwall and Eekelaar (1988) draw back from this version of Foucault's disciplinary society, claiming that while the State has unquestionably become more regulatory of the care of children within the home since the 19th century, critiques of State regulation rely too heavily on a romantic view of individual liberty and how it impinges upon children. Dingwall (1982) cites the arguments of John Stuart Mill to justify a regulatory approach by the State towards children. In 'On Liberty' (1859) Mill asserts that, in the case of children, ideas of liberty can be an obstacle to the State carrying out its duties, because parents so highly value their own freedom to act without interference.

The Victorian era saw the emergence of 'collectivist' ideas about children, as manifested by the rise of health visiting and the State's new (if reluctant) willingness to protect the future of the 'child of the nation' by means of legislation. During this period care-givers became increasingly responsible to the State and its agents, adding to the perception of children as a national responsibility (Stainton Rogers 1993). An essentially protectionist ideology dominated social policy, within which children were perceived as inherently

[10] In a qualitative study (n = 135) Mayall (1986) found this ambiguity well recognised by mothers using the health visiting service. 92% of interviewees thought that one of the health visitor's roles was to 'help them with what they themselves identified as problems' (p163), while 61% of mothers identified a further role which was to 'inspect and make sure children were well cared for' (p164).

vulnerable and in need of special treatment to ensure their well-being (Harding 1999). A sea-change came about in the 1980s when 'laissez-faire' and individualist ideals challenged the collectivist view of children (Dingwall and Eekelaar 1988). In the 1980s there began to be a retreat from the idea that the State should actively monitor the care of all children. The protectionist ideology was being eroded by a paradigm within which the State should intervene only as last resort, not acting to prevent family breakdown or harm to children, but picking up the pieces when a family has collapsed (Dingwall 1982).

The Jameson report has been chosen as the key event for this section, because it played an important part in defining the lines of responsibility for children's welfare. Under the 1948 Children Act social workers had been given statutory responsibility for child protection (Malone 2000). The 1956 Report on the Field, Training and Recruitment of Health Visitors recommended that the primary concerns of health visitors should be health education and 'social advice', and that they should work as 'medico-social workers', primarily with mothers and young children (Jameson 1956). Unlike the Younghusband report (1959) which made a forceful case for the expansion of social work the Jameson report failed to define the field of health visiting (White 1985).

It has been suggested that Younghusband's successful demarcation of a specialist area for the qualified social worker was accomplished at the expense of the traditional work of health visitors (Welshman 1997)[11]. The consequences of this role division are still felt in safeguarding work, where health visitors *de facto* deputise for GPs by taking responsibility for child protection within the primary healthcare team (Lupton, North and Khan 2001), as part of the heterogeneous health visiting role. Lupton, North and

[11] In contemporary child protection practice there was much overlap between the roles, with health visitors taking on more complex social problems when social workers were understaffed (White 1985).

Khan (2001) consider that the under-recognised nature of health visitors' child protection work has led to insufficient understanding and acknowledgment by policy makers of the part child health surveillance plays in safeguarding children.

From the early demands of working women's self-help groups (Robinson 1982) to Gimson's (2007) survey of mothers' attitudes, health visiting has been generally appreciated, tolerated and requested by mothers (Mayall 1986, Oakley 1998, Bowns *et al* 2000)[12]. Given the problematic nature of the 'the delicate advisory/surveillance role' (Hendrick 1997, p319), it is interesting to consider why health visiting has such widespread acceptability[13]. Dingwall (1982) attributes the acceptability of community nursing paradoxically to its deliberate avoidance of a social policing style of work, and the distinctive way in which nurses have managed the compromise between enforcement and libertarian values:

> 'There is a basic tension in a society like ours between wanting the State to act on our behalf to achieve certain ends and maximizing our individual liberties. The strength of community nursing may, ironically, have been its inattention to this debate in political philosophy. Historically, community nurses have found pragmatic remedies when they have encountered *ad hoc* difficulties. In this process, they seem to have developed a workable and socially legitimated compromise between intervention and liberty, trading off one against the other. The crisis for community nursing, as for so many State agencies, is the erosion of confidence in that compromise.' (Dingwall 1982, p345)

The infinite variety of the health visiting role, in which elements as various as child health surveillance, health advice and parenting support coexist with monitoring for signs of abuse, has been well discussed within health visiting (e.g. Twinn 1991, Billingham 1991, Chalmers 1992, Byrd 1995, Cowley and Appleton 2000). Particularly interesting work has been done on how health

[12] A recent example of capitalising on the popularity of the health visiting 'brand' has been pledges by the Conservative party, if elected, to increase health visiting to all mothers, setting off the costs against reducing numbers of outreach workers in Sure Start centres (BBC News 15th March 2008).
[13] Nottingham and O'Neill (2000) suggest that nurses are viewed more kindly than comparable professions. For instance; '…while public opinion views the social work profession in the light of the actions of its worst practitioners, it sees nurses misdemeanors as exceptional' (Nottingham and O'Neill 2000, p193)

visitors carry out 'fringe work' which establishes a relationship with the family and paves the way for introducing the health visitor's therapeutic agenda (de la Cuesta 1993, 1994).The social aspects of the role, which have been the object of mild derision to some commentators ('health visitors are hamstrung by the conventions of medical gentility' (Bloor and McIntosh 1990, p 179)), may in itself be a source of strength. When Dingwall (1979) compared the approaches of male and female health visitors, he found that whereas a sample of male health visitors were at a loss when they could not exhibit superior expert knowledge, female health visitors excelled at working with clients where there was no pre-determined agenda. Similarly, Pritchard (2005) suggested that health visitors draw on their personal life experiences when working with clients, as well as professional knowledge and experience. These findings reflect the earliest assumptions about health visiting, that it is an acceptable intrusion into the family home because of the gendered attributes of the female worker (Davies 1988).

1.6 Assessing children's development

Key event- the 1976 Court Report

Scientific interest in the development of children began with individual studies of individual children. From the mid 19th century English biologists, such as Darwin and Galton, advocated a scientific approach to the study of children. Galton established an 'anthropometric laboratory' where children's development could be measured in order to assess capability and identify remediable defects (Court 1976). In 1896 Sully founded the British Child Study Association, which advocated the study of child development, by examination of normal as well as abnormal children, to gain insight into the individual child (Court 1976). This new construction of childhood, as the object of scientific study, came to be influential within the public health movement, and part of the drive to improve the health of children. Hendrick (1997) describes the growing interest in child development as being powered by three sources; firstly, the interest of biologists and natural historians in

knowing more about child development, secondly, public concerns about the extent of medical and physical handicap among school children, and thirdly, anxiety about the combined effects of racial degeneration and poverty upon children.

Universal schooling introduced a need to separate children who were considered educable from those who were not. Early legislation was concerned with educational provision for children with physical and mental handicaps. The Blind and Deaf Children's Act of 1893 attempted to separate such children from 'imbeciles' and to give them appropriate education. Throughout Europe, there was a perceived necessity for tests by which the 'feeble-minded' could be identified, in order to separate them from mentally and physically healthy children, and exclude them from mainstream schooling (Rose 1990). Eugenicist ideas were very influential at the end of the 19th century, with many leading intellectuals belonging to eugenic societies (Oakley 1997). Hendrick (2003) describes how a variety of people, both politicians and reformers, commonly used the vocabulary of eugenics to address the issues of the day. Supporters of ideologies centred on eugenics, 'social waste' and social Darwinism put pressure on the government to develop policy on feeble-mindedness (Hendrick 2003). Legislation for children with physical and mental handicaps fulfilled two aims, firstly to promote the welfare of children and secondly to provide the means to control elements of society who might in the future prove troublesome, either through dependency or disruptive behaviour.

The idea that child development was something that could be assessed and measured spread to the informed middle-classes. At the turn of the century parents could buy charts of childhood milestones, showing the ages at which a child could be expected to sit, walk or talk, which could be used to assess the progress of their own child. Thus ideas about the measurement of children moved from the field of science to the domestic arena,

demonstrating how institutional health and education systems are influential in reproducing ideologies among the population (Doyal 1979). Armstrong (1983) has described how increased social surveillance in the late 19th century (in schools and the clinics) raised the consciousness of health matters in the community, making the private individual part of the surveillance machinery. The aim of education was not only to educate the child, but to inculcate social norms, particularly of behaviour. Davin (1978) argues that the best justification for girls being included in compulsory education in 1870 is that the government sought to inculcate stereotypical beliefs about male and female roles. Education for girls always included a domestic curriculum, which was extended as a recommendation of the 1904 Committee on Physical Deterioration. In this way the State sought to influence the upbringing and care of children within the home[14].

In the inter-war years Gesell, an influential American psychologist, sought to develop more scientific and reliably predictive developmental tests which would show whether a child was developing normally or was lagging behind its peers (Gesell 1950). Empirical research was carried out on large numbers of children to establish normality of development at each age, under conditions of the utmost scientific probity (Fawcett 2000). Children were brought into study centres where they could be examined in '*in vitro*' laboratory conditions, with the expectation that the findings derived from the study of American middle-class children could be extrapolated to any child from whatever cultural or experiential background (Bradley 1989). The observational methods used by Gesell imitated Foucault's panopticon[15], by means of which intimate observation can be carried out with detachment

[14] Elementary education was never intended to enable women to compete with men for jobs, nor to provide additional educational opportunities for boys or girls (Davin 1978). The 1902 Education Act limited the curriculum of elementary schools in order to put an end to the practice of teaching an extended curriculum to more able children.

[15] Foucault developed Bentham's idea of the panopticon as the model prison, and applied it to modern industrial society where institutional training and discipline can be seen to induce docility to surveillance among the population (Swingewood 2000, Reeves 2007).

(Armstrong 1983). Gesell's ideas were enormously influential among doctors, and the tests he developed in the 1920s still form the basis of developmental assessment tools which are used by paediatricians and child health professionals.

Sheridan and Illingworth brought Gesell's pioneering ideas to England and adapted the developmental assessment tests for British children (Mitchell 1977). These tests were not used on all children, but only those identified as being 'at risk' of developing physical, mental or social handicaps. Such children were listed on locally held 'at risk' registers, and tested routinely for developmental progress by a doctor specialising in child health (Sheridan 1967). Registered children included those from families with a physical or mental disorder, those who experienced morbidity around the time of birth or exhibited delayed development, and 'problem families'. Much criticism existed of 'at risk' registers. It was pointed out that using the Sheridan criteria around 60-70% of children in Britain could be considered 'at risk' (Oppé 1967). Court (1976) considered 'at risk registers' an economical substitute for total child population screening, and opposed the spread of such registers to children living in circumstances of social disadvantage. The alternative suggested to 'at risk' registers was not to abandon screening, but to widen it to the whole population. Richards and Roberts (1967) suggested that all children should have their developmental progress monitored by doctors, supported by health visitors.

Court expanded upon this idea in his 1976 report on child health services, 'Fit for the Future'. It was recommended that, in place of 'at risk' registers, screening should be available for all children, within an integrated child health system. To resolve the duplication of services between GPs and community clinics, GPs with additional specialised training in child health (GPP) would provide a comprehensive child health surveillance service for children. Health visitors, who would also receive more paediatric training

(CHV), would assist doctors in carrying out developmental assessments, and following up non-attenders at home. GP attachment for health visitors was recommended to cease, in favour of a return to traditional geographical ‘patches’ of health visitors’ responsibility, to ensure the maximum inclusion of children in the programme and reach those least likely to attend. Court (1976) set out a basic minimum framework on which health surveillance should be based (see table 1.1 below). The timings of contacts were set to allow for development assessments at key stages, especially checks of vision, hearing and language, and to anticipate parents’ need for advice on ‘normal’ developmental problems. All children would be offered this programme, with more frequent contacts for children identified as having a greater need.

Table 1.1 Court's 'Schedule for basic surveillance programme' (Court 1976)

Age (approx)	By whom	Where
At birth	To be organised by hospital consultant or doctor providing maternity care at home	Maternity unit or home
6-10 days	Doctor	Maternity unit or home
6 weeks	GPP or consultant paediatrician CHV (for non-attenders)	Clinic (a clinic could be held at a GP surgery, health centre or child health clinic)
7-8 months	CHV	Clinic or home
18 months	CHV	Clinic or home
2.5 - 3 years	GPP or CHV	Clinic
4.5- 5 years (immediately prior to school entry)	GPP	Clinic or school

Abbreviations
GPP: general practitioner paediatrician
CHV: child health visitor

For a brief period after the Court report it seemed that child health surveillance would become a high status skilled activity for specialist GPs and health visitors. A study by Drillien and Drummond (1983) was counted by many as proving that routine professional assessment was successful in identifying children with disabling conditions, who would otherwise be missed (Court 1984, Bax and Whitmore 1990). But even as Court made his 'Fit for the Future' recommendations there was dispute from within the medical profession about whether universal developmental screening was either feasible or desirable. From the1970s critics suggested that regular developmental examination was not supported by evidence (Hutchison 1973, Bain 1974).

Although routine child surveillance as a means to promote optimal development was still seen by many as beneficial (Bain 1974, Starte 1976, Jenkins 1984, Raikes 1984, Walker 1986), others argued that even this was redundant in a climate where child health was seen to be improving (Bryant 1986). Evaluating child health surveillance programmes by numbers of new disabilities identified at each review was no longer meaningful as most disabilities were identified at, or soon after, birth, and the general decline in morbidity meant that many conditions appeared very infrequently in any one district (Hampshire *et al* 1999). Children did not seem to be suffering in the same numbers from the same conditions, but a new morbidity had developed which involved behavioural and psychosocial conditions which were difficult to identify and treat (Oberklaid 1988, Heussler, Polnay and Katz 2000). The Court report did not succeed in establishing an integrated child health service, but instead heterogeneous practice continued to be carried out throughout England (Macfarlane and Pillay 1984, Hall 1989a).

1.7 Conclusion

Well-children health services developed in a sporadic and reactive way to perceived needs of the time, rather than there being any overarching overview of the direction of a national preventive paediatric health service. Social policy towards children's health services has developed incrementally, owing its progression to opportunism, pressure from the public and professionals, and the balancing of the State's concern for a future healthy population with financial and social costs. Modern accounts of the development of children's preventive health services agree that paternal rationalism, which was previously taken for granted as the driving force for change, played only a contributory part (Boaden 1997). Perhaps the most significant determinant of the nature and development of children's health services has always been contemporary attitudes to the duality of children's identity, as people now and as people in the future. Mayall (1998) describes

how adult care and intervention in childhood (by mothers, health visitors, doctors and teachers) is seen as having importance for the future, because it shapes children's minds and bodies in a way that will affect their adult lives. Changing public, professional and governmental views on the value of this social process direct the form of children's preventive health services. The next chapter explores the reform of child health surveillance policy that began in 1989, and how this has progressed to the present date.

Chapter 2

Preventive health services for children 1989-2008

In 1989 a working party chaired by David Hall, a leading British paediatrician, proposed a national child health surveillance programme to be carried out through England and Wales. This programme was published in 'Health for all Children' (Hall 1989a), which is the first edition of what is commonly known as the Hall report. Subsequent editions have been published (Hall 1991, Hall 1996, Hall and Elliman 2003) which have revisited the national programme and suggested changes to the way preventive health services are provided to children. Reports have been produced describing the modifications made to local preventive child health services in response to the changed priorities of national policy (PHAAR development team 2003, Harrison and Garside 2004).

The four editions of the Hall report have successfully changed the face of preventive health services for children in the UK. As early as 1992 recommendations for a minimum core programme of child health surveillance were incorporated into health service guidelines (NHS Management Executive 1992), and subsequently the national core programmes of England, Scotland, Wales and Northern Ireland have been revised in the light of the Hall reports (Scottish Executive 2003, DH 2004a, Welsh Assembly 2005, Department of Health, Social Services and Public Safety 2006). Since the 1999 devolution of government to Scotland, Wales and Northern Ireland policy differences have developed between the devolved countries (Clews 2009), but within all parts of the UK preventive services for pre-school children have been reformed in line with the Hall report recommendations.

This chapter will look at the background to the publication of the first Hall report, and then examine how its central ideology of evidence-based medicine has shaped the form of the recommended core programme. After

considering the way the programme has developed over the course of the four editions of 'Health for all Children', the critical voices raised against Hall's programme will be presented and the main points of their arguments outlined. Finally, key aspects of the policy context in which Hall's national programme has been so warmly received by government and NHS policy makers will be sketched in. This will provide the reader with an understanding of the many factors which have contributed to the powerful effect the Hall reports have had upon health policy for well-children, and prepare the field for the ensuing account of the empirical research study.

2.1 'Health for all Children': the Hall reports

By the 1980s there was concern in the child health surveillance programme was insufficiently based on evidence of effectiveness (Hendrickse 1982), and that there was lack of equity in the provision of services (Macfarlane and Pillay 1984). Across the country there was variation in personnel delivering the programme, the ages of children to be tested and the screening tests done, and it appeared that each English health district ran a different child health surveillance (CHS) programme (Macfarlane and Pillay 1984). Butler (1989) found a paucity of scientific evidence about whether child health surveillance had any beneficial effect upon children's health, and revealed the extent of disagreement among the various professional groups as to what child health surveillance was, and how it should be carried out[16]. Against this background of dissatisfaction and strife, the British Paediatric Association, the Royal College of GPs, the General Medical Services Committee of the British Medical Association, the Health Visitors' Association and the Royal College of Nursing joined together in discussions and formed a working party which produced the first 'Health for all Children' (Hall 1989a).

[16] Both the Royal College of General Practitioners and the Health Visitors Association had tried to annexe child health surveillance for themselves (Royal College of General Practitioners 1983, Health Visitors Association 1985).

The first 'Health for all Children' working party concentrated on the content of the CHS programme and its scientific basis, and produced a core programme which included only those screening tests and procedures for which there was considered to be scientific justification (Hall 1989a). Developmental screening was specifically tested against Wilson and Jungner's (1968) and Cochrane and Holland's (1969) requirements of a screening test[17], and found to fall short of these criteria, leading to the conclusion that a comprehensive programme of developmental screening for all children is not effective. The key differences from previous child health surveillance programmes were: more emphasis on health promotion, a stronger focus on the role of parents in detecting disorders, fewer screening tests and procedures and a recommendation that the routine developmental examination of children be discontinued (Hall 1989a). This has meant that defined screening tests for known serious conditions have been retained (e.g. neonatal blood tests for phenylketonurea and hypothyroidism), while sequential universal observation of development has been discarded.

The first CHS programme proposed by Hall generally conformed to the accepted pattern of routine contacts prevalent at the time (Hooper and Alexander 1971, Rowlands 1975, Jacobs and Hall 1976, Lancet Editorial 1986). More changes were made to the recommended programme in subsequent editions, as each further edition of 'Health for all Children' reappraised the programme offered to babies and children, and, in the light of the research evidence available, decided which interventions to include or exclude. The final proposed core programme is then described as the current 'best buy' in view of the existing evidence. The result has been a striking reduction in the numbers of routine universal contacts offered by health visitors and GPs to children, with the result that 'we now have the leanest well child programme in the Western World' (Hall 1998a, p1). The role of

[17] Wilson and Jungner described how screening programmes could be evaluated; Cochrane and Holland described the characteristics of an ideal screening test (Hall 1989a).

parents is central to the functioning of this 'lean service'. While the majority of parents are considered able to notice that a child has a problem and seek help appropriately (Hall 1996), it is the role of health professional, particularly health visitors, to judge which parents are less able to do this and to continue to provide routine appointments for child health and development reviews in these cases (Hall 1996).

While the first edition was a modest volume, which predominantly consisted of the recommended programme and the rationale for its adoption, later editions have taken a wider perspective on child health, making recommendations on every aspect of well child care. The second edition (Hall 1991) defined responsibility between GPs and health visitors for different parts of the programme. It is noteworthy that even though Hall recommended that GPs carry out certain tests (see table 2.1) there is much evidence that in practice most child health surveillance was being carried out by health visitors even prior to the first Hall report (Steiner 1977, Devlin 1985, Nicoll *et al* 1986). The third edition (Hall 1996) proposed a change of name from child health surveillance to child health promotion. This reflects a departure from a medical model of screening for disorders, and avoids the 'Big Brother' connotations of the word 'surveillance', which had been found distasteful even in the first report (Hall 1989a). The fourth edition of 'Health for All Children' reduces routine contacts even further by suggesting that staff should take 'a flexible approach' to reviews after four months, as after this point 'face to face contact may not be necessary for all families' ((Hall and Ellimann 2003, p.xix). Work on a fifth edition is now in progress.

While each edition of the Hall report has stressed that the core programme should be the minimum offered, with more effort put into targeting those who do not readily present their children for child health surveillance, the fourth edition represented the biggest step in the move towards a predominantly targeted service. The justification for this was that more resources should be

devoted to the ‘most needy’ children while reducing the time spent on children whose parents can be relied on to seek help if worried (Hall and Bedford 2003). Health visitors, who are noted as being highly paid in relation to other nurses, are stated to be well able to identify children requiring more input because they are independent professionals and know the children on their caseload well (Hall and Bedford 2003). In addition the primary healthcare team (PHCT) as a whole are required to assure themselves at each stage (8-12 months, 2 years and 3.5 years) that no new problems have emerged (Hall and Elliman 2003). To do this they must function well as a team and maintain good liaison with those in contact with children such as nursery workers. By the fourth edition Hall and Elliman (2003) describe Sure Start schemes, schools and child care workers as making an expert contribution to identifying children whose health and development requires further evaluation, and call for their skills to be enhanced by further training.

Table 2.1 below shows the progressive changes made to the core programme in each of the four editions. It should be noted that accompanying the reduction of screening procedures has been a reduction of routine health professional contacts with children, in particular a reduction in the frequency of health visitors’ contacts with children.

Table 2.1 The evolving core screening programme in the 'Hall reports'

	Health for all children 1989 (ed D Hall) (134pp)	Health for all children 1991 (2nd edition) (ed D Hall) (171pp)	Health for all children 1996 (3rd edition) (ed D Hall) (250pp)	Health for all children 2003 (4th edition) (eds Hall and Elliman) (408pp)
Name of programme	Child Health Surveillance	Child Health Surveillance	Child Health Promotion Programme	Child Health Promotion Programme
Prescribed ages for pre- school screening *	* Neonatal * 10 days * 6 weeks * 8 months * 21 months * 39 months Plus weighing at each clinic visit	* Neonatal * First 2 weeks * 6-8 weeks * 6-9 months * 18-24 months * 36-48 months (Opportunity to consult health professional at clinic visits at 2,3,4 months)	* Neonatal * First 2 weeks * 6-8 weeks * 6-9 months * 18-24 months * 3 ¼ - 3 ½ years (Opportunity to consult health professional at clinic visits at 2,3,4 months)	* Neonatal * 5-6 days * 6-8 weeks (see member of PHCT at 2,3 and 4 months clinic visits for immunisations and weighing) Contacts after 4 months according to need.
Who should carry it out?	'We have deliberately avoided the question of which professionals should carry out the various tasks... appropriate knowledge skills and attitudes [are] more important than the individual's original professional background.'[18]	* Neonatal- hospital * First 2 weeks- GP * 6-8 weeks- GP (preferably HV present) * 6-9 months- HV or HV and GP* 18-24 months- HV * 36-48 months- HV and GP	* Neonatal- hospital/GP * First 2 weeks- HV * 6-8 weeks- PHCT usually GP (preferably HV present) * 6-9 months- GP and HV or HV * 18-24 months- HV * 3 ¼ - 3 ½ years- GP or HV (very brief if no identified health needs)	* Neonatal- hospital/GP/midwife * home visit in first 10 days- worker not specified, lay workers could support breastfeeding * 6-8 weeks- PHCT usually GP
Significant changes	'We recommend [this] core programme of surveillance for all children. It incorporates those screening procedures which we believe can be supported in the light of the available evidence.' [19]	'[Following the new GP contract] …the working party felt that…the difficult issue of 'who does what' which was carefully avoided in the first edition could now be addressed.'[20]	'The theme of [this] edition is child health promotion. Its message is that preventive health services for children extend beyond the narrow remit of child health surveillance.' [21]	'After 4 months the HV should negotiate the nature of subsequent reviews. It is up to parents and professionals together to decide what should be done in the light of individual needs and inevitably of competing priorities.'[22]

[18] Hall 1989, pix
[19] Hall 1989, p99
[20] Hall 1991, pxii
[21] Hall 1996, p9
[22] Hall and Elliman 2003, p355

In 2004 the programme advocated by the 4th Hall report formed a central part of the 'National Service Framework for Children, Young People and Maternity Services' (DH 2004a), a document which sets out strategy for children's services in England for the next 10 years. The process by which the National Service Framework (NSF) was developed is described in the report from the National Clinical Director for Children (DH 2005a). Professor Hall had an advisory role in the process but was not a member of the external working group for preventive health care, which allowed the working group to 'take a fresh look at the evidence' (DH 2005a, p26). The fourth edition of the 'Health for all Children' was used as a starting point for the programme recommended in the NSF, but further evidence-gathering did take place by means of specialist working parties (Sloper and Statham 2004). The NSF working group found evidence for the utility of many aspects of preventive child health care, including injury prevention, promotion of healthy diet and physical activity, support for parenting, and mental health promotion (Licence 2004). One very significant difference between the core programme advocated by Hall and Ellimann (2003) and that of the NSF for Children (DH 2004a) was that the age at which the health visitor should decide future level of intervention (i.e. decide whether the child needs to be targeted) was moved upwards from four months to one year (see appendix 2.1 for an overview of the programme).

2.2 Hall's rationale for reform

The dominant guiding principle behind the Hall reports is that of evidence-based medicine. Cochrane's criteria (Cochrane 1972) by which treatments should be judged were applied to all interventions included in the child health surveillance programme. The criteria are;

- Effectiveness- Does the treatment alter the course of the disease for the better?

- Efficiency- Does the input justify the output? Is the treatment cost-effective?
- Equality- Do all parts of the population have equal access to services?

In applying these criteria to child health surveillance, the working party therefore not only made judgements about the effectiveness of interventions, but also about cost-effectiveness and accessibility. Hall specifically refers to the need to control both the costs and scope of clinical practice in the 'Health for all Children' reports and supporting articles. In the introduction to the third edition (Hall 1996) he makes clear the twin goals of effectiveness and cost-effectiveness;

> 'Limitations in resources and demands for a rational approach to resource allocation have made it essential to evaluate all health care activities and seek the most cost-effective means' (Hall 1996, p. vii).

In explaining decisions about the content of the programme, Hall (1998a, 1998b) laments the lack of strong evidence, which means that decisions have often to be made on the basis of inadequate data. He justifies his decision to make changes using inadequate evidence by stating that while, in an academic sense, it would seem preferable to wait for further research, in practice research evidence is a subordinate consideration to economic pressures and health service reorganisation, which are more powerful drivers of change (Hall 1998a). Many authors have called for further research in order to establish more clearly the validity and efficacy of child health surveillance (Dworkin 1989, Elkan *et al* 2000a), though it is acknowledged that such studies would need to be large, longitudinal and therefore expensive (de Winter *et al* 1995). Hall (1996) asserts that longitudinal studies, which would provide evidence, are too expensive to carry out. Despite the emphasis on the importance of basing practice on good evidence, it does not appear that any systematic and large scale evaluation of the core programme has yet taken place.

One example serves to show the difficulties encountered in attempting to apply the principles of evidence-based medicine to aspects of the programme where the evidence is not clear cut. The sequence of four Hall reports demonstrate changing recommendations for screening for congenital dislocation of the hip (CDH), which has been historically the most expensive area of litigation in child screening (Hall and Matthews 2002). The first Hall report (1989a) cites CDH as one of the disorders that probably benefits from early detection, although the evidence is not conclusive. It is stated that, as the condition is unlikely to be noticed by parents and only detectable by health professionals, the child should be specifically examined for this condition (Hall 1989a). In view of the fact that all CDH cannot be detected at birth (even experienced examiners will produce false positives and overlook some cases) the expert working party considered that 'the possibility of CDH' should be considered whenever a child is seen in the first 2 years of life' (Hall 1989a, p. 21). However, by the fourth edition, following further consideration of research evidence, it is stated that no further examination of the hips should be done after the 8-week check. Instead, details of the signs and symptoms of DDH (developmental dysplasia of the hip- the new preferred term) should be included in the parent held Personal Child Health Record in order to 'alert parents and professionals to the possibility of DDH' (Hall and Ellimann 2003, p. 157). The rationale for this is that screening should not be done routinely because of lack of knowledge about the course of the disorder or about appropriate treatment.[23]

Providing evidence-based guidelines for clinical practice was intended to reduce the costs of litigation to the health service. This is not only at the level

[23] In the third edition of 'Health for all Children' (Hall 1996) it was stated that because of insufficient reliable evidence from research some children would receive inappropriate treatment (splinting) which holds potential risks, some cases would be missed, and some children who received splinting would still require surgery because splinting had been ineffective. An overview of DDH screening strategies concluded, 'Policy choice depends on values attached to different outcomes, willingness to pay to achieve these and total budget' (Brown *et al* 2003, p766).

of clinical tests and procedures, but extends to the advice to be given to parents. In an article on audit and risk management, Hall and Matthews (2002) suggest that advice given by health visitors and midwives should be closely monitored because of the risk of litigation against their employers, the NHS Primary Care Trusts. For instance, if a health visitor failed to explain vital health issues to a parent this could be viewed as a breach of duty of care. The salutary example is given of a mother who took legal action against a primary care trust because she claimed that she had not been told that smoking is a risk factor for Sudden Infant Death Syndrome (Hall and Matthews 2002). Thus the level of accountability for the practice of community nursing staff within the CHPP was raised and made explicit. Rather than being an activity solely done for the benefit of the child and family, CHPP advice became also a defensive measure to protect the Trusts against litigation costs. Within this context it is interesting to consider further the example of CDH/DDH where risk was reduced by ceasing to screen for the condition.

2.3 Criticisms of the Hall reports

The changes to the national child health surveillance programme proposed by Hall were welcomed by many as a means of reconciling the disparate practice which had previously taken place, and introducing a standardised programme. Colver (1990) suggested that the alternative to a standardised programme was that each district or primary health care team should continue with different programmes ‘in the vain hope that it has found the perfect programme and can implement and evaluate it’ (Colver 1990, p142). Despite general acceptance and wholesale adoption of the recommendations there has been a persistent series of often lone voices which have been raised against the snowballing influence of the Hall reports. A sample of these criticisms are worth looking at in more detail, because they reflect not only objections to how the programme works in practice, but also raise ideological questions about the approach taken by the ‘Health for all

Children' series to children's preventive health services. This sample of prominent criticisms is presented in chronological order.

2.3.1 An early response

Two community medical officers (CMOs) responded very critically to the first Hall report, branding it 'muddled and contradictory', and sometimes plain 'daft' (Bax and Whitmore 1990, p141). The main objection was that strict criteria for screening tests should never have been applied to child health surveillance, which is not itself a screening test. They accused Hall of thus setting up an 'Aunt Sally', which can easily be knocked down to 'prove' that methods of developmental screening are ineffective (Bax and Whitmore 1990). Other points made are that there is no research evidence that the parents of all children can be relied to spot children's developmental problems, and that some claims made in the Hall report (such as there being no effective treatments for speech and language disorders[24]) are untrue.

In an interview for the 'Health Visitor' journal (Potrykus 1989), Bax and Whitmore raised the issue of what preventive health care a society should provide for children and whether children have a right to have their problems identified at an early age. Bax (1976) had previously dismissed arguments about not screening for conditions for which there is no effective treatment, because of the lack of parity with the way adults are treated by health services:

> 'It seems to me that it would be as wrong to ignore breast cancer because our methods of treating it are not very good at the moment, as it would be to ignore [a] child with [a] communication problem because we are not really sure how we should handle him' (Bax 1976, p387)

[24] Law (1989) a child language development specialist, also claimed that Hall was either not up to date with some aspects of relevant speech and language research, or chose to ignore it. He considered the proposed CHS changes were cost-driven and suggested that prior to reducing the existing system it should be evaluated.

Bax and Whitmore (Potrykus 1989) argued that ‘at risk’ registers, the equivalent of targeting, had been unsuccessful, and insisted that universal routine contacts with a health professional are needed to help children with both minor and major problems, and prevent children ‘slipping through the net’.

2.3.2 Comments from abroad

A very interesting critique of Hall’s reforms is presented by de Winter *et al* (1995, 1997). In the 1990s questions about the effectiveness and cost-effectiveness of child health surveillance were being asked in Holland, and a working party was formed to review the Dutch CHS system. The method used was described as analogous to that of Hall (1989a), but the Dutch working party reached very different conclusions. While acknowledging the inadequacy of developmental screening tools, developmental screening was perceived as having value because of the need for a ‘low-threshold’ service capable of detecting problems and facilitating early referrals. Members of the Dutch working party were concerned about the rights of the child, admitting themselves ‘rather sceptical about the role ascribed to parents in the United Kingdom’ (de Winter *et al* 1995, p144). They wished Dutch children to be seen regularly to prevent parents becoming worried about their child, and to be able to ensure that each child was attaining its optimal health status. In affirming the usefulness of the system the working party took into account the established nature of the programme, and its acceptability to parents and a families, a wider frame of reference than had been permitted in the British evaluation.

On a smaller scale Bremberg (2000) considered the evidence-base for the Swedish system of child health surveillance in the light of Hall’s proposed reforms. At the time the Swedish pre-school programme consisted of 15 examinations by a nurse, 5 examinations by a paediatrician, 7 assessments of development, two assessments of hearing and one assessment of visual

acuity. Bremberg (2000) concluded that the evidence for the current Swedish programme was of poor quality, but considered that the lack of evidence was countered by the strong support for the programme among parents and health professionals. This support stemmed from longstanding familiarity with the tradition of examinations for children, the opportunities provided thereby for health promotion, the difficulties of defining which children are 'at risk', and the function of the procedure as a 'supportive ritual' for parents (Bremberg 2000, p10). He recommended that when analysing the health surveillance system it was important to consider both the 'scientific' evidence' and the reasons for the popularity of the programme.

2.3.3 A contextual policy evaluation

Butler (1997a, 1997b) conducted an investigation into how the recommendations of the first Hall report worked in conjunction with other significant policy changes, such as the 1990 new GP contract and the NHS and Community Care Act (1990). Both managers and service providers considered that 'Health for all Children' (Hall 1989a) had increased standardisation of surveillance programme in many places (though marked variations still existed) and prompted health authorities to develop more explicit policies for child health. Health visitors and CMOs did not consider that it had reduced the use of tests of dubious value or improved the quality of surveillance. The losers from the changes were CMOs who remained excluded from the mainstream child health services, and health visitors, who found themselves under pressure to provide a more targeted service. Health visitors considered that their surveillance work now overlapped with GPs, and felt that their autonomy in identifying priorities and making referrals had been curtailed. Additionally, the internal market introduced new values towards child health services and more attention was paid to controlling the costs. Both CMOs and health visitors worried that fundholding GPs could cut corners in developmental checks, and that purchasers were failing to provide the service required by the children with the highest health needs. Butler

(1997b) concluded that the reforms had led to unanticipated and unwanted consequences, as well as desirable change.

2.3.4 A professional challenge

The response of some professionals was very much coloured by the potential impact of a more truncated programme upon their practice. A leading optical expert (Fielder 1998) described his response to the systematic review on pre-school vision screening as initially one of professional defensiveness ('Have we been completely wasting our time over the past few decades?') but he rallied to defend routine screening, with the result that it was retained despite a systematic review claiming to show a lack of evidence (Snowdon and Stewart-Brown 1998). The review recommended that given the inadequacy of the evidence (particularly no study having been conducted where a control group was untreated) screening should only be continued as a controlled trial. One of the key messages of the review was that;

> 'Amblyopia (short-sightedness) is probably not very disabling; while the possibility of being visually disabled by the loss of the one good eye by accident or disease, is important, numerically it is probably not enough in itself to justify screening.'
> (Snowdon and Stewart-Brown 1998, p13)

Fielder (1998) made the following criticisms of the conclusions of the systemic review: the evidence was not strong enough to support the conclusions[25], no trials have been conducted with a no-treatment group because this would have been considered unethical, it is not known how visual defects impact upon life activities (such as education, social interaction and work), and there is some evidence that amblyopic individuals have an increased risk of losing the better eye through injury or disease. Interestingly the reasons given by Hall (1998b) to justify the continuation of pre-school vision screening were not related to scientific evidence. It was concluded that

[25] In particular that the systematic review had placed undue emphasis on a small number of studies which suggested that amblyopia could spontaneously resolve (Fielder 1998).

although there was insufficient evidence to recommend universal routine orthoptic screening, in practice pre-school vision screening should be retained, because;

> 'There is a political or parental dimension. It is counter-intuitive to suggest that vision screening is not useful. Many parents are angry and upset at the discovery of amblyopia at age 7 or even older in some cases… parents feel strongly about the early identification of important medical conditions. The fact that a particular disorder is not treatable in the strict medical sense of the term, or that the benefits of any treatment might be modest, does not alter their views on the subject.' (Hall 1998b, p13).

Additionally it was felt that if screening was stopped, some parents would take their child to a high-street optician for an eye check, which would increase inequity between socio-economic groups, and (after reimbursement of opticians) probably equal the cost of screening all children at school (Hall 1998b). This example is instructive because it demonstrates how not all decisions are made on the basis of 'hard science'. Some professional groups were able to make a successful challenge to retain their routine practice with children; it is likely that the ability of groups to mount this challenge successfully is dependent upon their status within the NHS and among those who make decisions about services. This disadvantages less powerful groups, such as health visitors, where it seems that no 'counter-intuitive' arguments were made to ensure that their services were not reduced.

2.3.5 The implications for health visiting

Kelsey and Robinson (1999) discussed the systematic reviews of screening in child health (NHSE National Screening Committee 1997) in the light of their effect upon health visiting. They question the relationship of evidence-based research findings to practice, raising issues about the external validity of results, difficulties in maintaining and extending the evidence-base, and the costs of implementation. The authors made the point that while systematic reviews have been concerned with the detection and treatment of specific medical conditions, health visitors see child health surveillance as an

assessment of the whole child, and are far more concerned with the social context in which children live, and wider influences upon health. In this they echoed Bax and Whitmore (1990) who considered that child health surveillance is a skilled examination and assessment of the whole child, rather than the application of a number of validated tests. Kelsey and Robinson (1999) asserted that while individual components of the CHS programme may be seen as ineffective, in combination they permit the child to be seen by a health professional. Such contacts facilitate and make possible other important aspects of health visitors' role, such as child protection work with families. In preference to allowing health visiting to be reduced, as a side-effect of reduction of routine CHS, Kelsey and Robinson (1999) suggested that a randomised controlled trial should be carried out to assess the effectiveness of health visiting in child health surveillance.

2.3.6 A response to the 4th edition (2002)

A significant protest against the fourth edition of 'Health for all Children' was made at a meeting of the British Association for Community Child Health (BACCH), an organisation of community paediatricians. Reviewing a draft of the 4th edition of 'Health for all Children' (Hall and Elliman 2003), members expressed concerns that many of the recommendations were not supported by evidence (Hutchison 2002). Issues described as contentious included the move away from universal checks after 6-8 weeks, the negotiated 'sign-off' at four months, lack of evidence that parents would identify problems and the absence of screening for post-natal depression. Hutchison, the BACCH convener, asked the authors to consider 'whether it is sensible to publish a document containing recommendations that are not supported by jobbing practitioners' (Hutchison 2002, p3). In his personal opinion, Hutchison (2002) considered that the report would be used by commissioners to reduce existing services for children, without re-investing in alternative and targeted services. Highlighting the magnitude of the change to the child health promotion programme, he suggested that;

> ‘Although ‘‘Health for all Children 4’ does not threaten to close hospital buildings, it may be that in terms of national impact far larger resources are involved.’ (Hutchison 2002, p3).

2.4 Factors contributing to the success of the Hall reports

Despite the criticisms described above, the Hall reports have been very successful in shaping UK policy concerning health service provision for well children. It is clear that, when Hall and the child health working party proposed change, their seeds of reform fell upon fertile ground. The proposed changes and the form they took were highly suited not only to the direction of health policy, but also to changing ideas about the role of the State in intervening in family life. While the epistemology of evidence-based medicine has provided the major driver for reform, other policy influences have also contributed to the readiness to accept the need for change, and the acceptance of change in this form. These other influences are often hidden behind the apparent simple good sense of ensuring that practice is based on research evidence.

From the perspective of the policy process, it is apparent that revising the balance between universal and targeted services has been a key theme in reshaping preventive services for well-children. A number of factors have contributed to this decision to target preventive health services, and hence health visiting services, for pre-school children. These include the various different influences identified in Chapter 1 including changing ideologies of childhood on the one hand and health promotion on the other, the power dynamics between health professions and changing patterns of health service re-structuring. These (and other) factors have contributed to wide-spread acceptance of the superiority of targeted services in meeting the needs of the most socially excluded and in redressing health inequalities.

The next section will 'fill in' the policy background to the Hall reports, aiming to illuminate those shifts in thinking, which have transformed the social and political climate in which policy is made. This will contribute to an understanding of the factors which have led to the Hall reports being so influential in determining policy for children's preventive health services.

2.4.1 Evidence-based policy and practice

The ideology of evidence-based medicine has been hugely influential in modern health care (Davies and Nutley 1999). As the dominant doctrine currently guiding medicine, evidence-based medicine, or rather those who apply evidence-based medicine to policy and practice, have great power to dictate which services should be offered. Foucault (1980) claimed that the power structures within society could not operate without 'discourses of truth', by which power is linked to correct knowledge and the idea of an indisputable 'right'. This 'right' has always been linked to dominance and subjugation of those who do not share this knowledge. The medical profession maintains its authority within the NHS by the supremacy of the medical model of practice and the position of doctors as relatively unchallenged guardians of knowledge (Lupton, North and Khan 2001). Medicine's 'monopoly of legitimacy' has led to dominance in influencing the development of health policy (Elston 1991). In the case of the CHPP the 'right knowledge' has been established as belonging to those who have led the reform of the programme and this has been established by the incorporation of their recommendations into the National Service Framework.

Harrison (1998) has examined the reasons for the success of evidence-based medicine and its widespread contemporary acceptance. While the idea of basing medical interventions and treatments upon research appears self-evidently good, this does not explain why it was only in the 1990s that this way of thinking began to dominate health policy. Before this date the complete scientific 'provability' of all medical interventions was not

considered a prime tenet of health service research. Harrison (1998) claimed that one of the prime reasons for the runaway epistemological success of evidence-based medicine is that it provides a legitimate form of rationing. One of the most important concerns of the 1990s was maintaining the affordability of the health service, in circumstances where demand was increasing (Edwards and Hensher 1998)[26], but GPs were more unwilling to continue their traditional role of rationing the demands upon secondary services (Holliday 1995). As implicit rationing had become less reliable, evidence-based medicine provided a form of explicit rationing which politicians and policy makers were happy to leave to doctors (Harrison 1998). The control that evidence-based medicine placed on doctors' clinical freedom was also welcomed in view of mounting pressures from the mid-1980s to increase managerial supervision of doctors and decrease litigation by the public against health services (Elston 1991). Evidence-based medicine performed the joint function of controlling the autonomy of doctors, and providing medicine with an impregnable foundation of scientific rationality (Harrison 1998).

From within medicine there has been criticism both of the way in which evidence is interpreted and the way in which evidence-based medicine is used to influence practice. While randomised controlled trials are universally recognised as excellent research methods, which are most likely to produce evidence on which practice can be based (Sackett *et al* 1996), they have their own distinct deficiencies which must be taken into account when conducting research. In order to ensure validity of findings, issues such as sampling and randomisation must be scrupulously addressed, and considered especially in terms of external validity (Jadad 1998, Greenhalgh 2001). Many trials conducted over the last 50 years have been found to be

[26] 'Little strong evidence exists to explain growth in demand for hospital services … but changes in population structure, numbers of people living alone, pressures on primary care, risk management, patient expectations and an increased ability to treat, are frequently cited as possible reasons for this seemingly inexorable rise' (Edwards and Hensher 1998, p135)

'biased, too small or too trivial' (Jadad 1998, p116). Systematic reviews and meta-analysis (Lilford *et al* 2001) and comprehensive literature searches (Egger *et al* 2003) also have potential methodological pitfalls to the extent of systematic reviews addressing the same issue reaching opposite conclusions (Lilford *et al* 2001). Davies and Nutley (1999) point out that when studies lack rigour they can mislead, meaning that changes are made to practice on the basis of flawed studies. Sometimes judgements are made about practice where insufficient good quality research exists upon which to base a judgement; in these cases the oft-quoted mantra of Altman and Bland (1995) - that absence of evidence of effectiveness is not evidence of ineffectiveness - is not always taken into account.

The difficulties encountered in clinical medicine in producing reliable research evidence upon which to base policy and practice and to incorporate that evidence into every day practice are multiplied a thousand-fold in prevention. An initial problem is lack of data upon which to base practice. Davey Smith, Ebrahim and Frankel (2001) have questioned the validity of the data used as a basis for public health recommendations in purportedly evidence-based documents. Taking the example of the Acheson inquiry (1998) they cite evidence from research which indicates that some of the recommendations would be ineffective and even harmful. Bhopal (1993) has highlighted the problems of applying an evidence-based theory of knowledge to any area of public health. The fundamental conundrum which makes assessment of the efficacy of public health interventions inherently highly complex is that, compared to socio-economic, lifestyle and environmental factors, health provision has little impact upon life expectancy and health status. Therefore, evaluation of preventive health services is unlikely to yield evidence of measurable benefit on the health of the population. While not denying the worth of evidence-based medicine as a contribution to methodological research, Bhopal (1993) rather ruefully comments on the

lasting influence of Cochrane's evidence-based criteria, and suggests that they have been used by hostile critics to undermine health services.

A final consideration is the lack of equality between professional groups in being able to engage in research which might substantiate their claims for benefiting patients. It is known that, despite being the largest profession in health care, nursing has considerable problems in attracting and implementing research (Rafferty, Newell and Traynor 2004). Until the 1980s there was little systematic investigation of nursing, and within nursing there was no infrastructure, incentive or culture to inspire or support research activity (Salvage 1998). Although the numbers of nurse researchers are gradually increasing, nursing research pathways are not clear. In particular there is no clearly established career pathway in which the nurse can combine research and clinical roles, unlike other applied disciplines such as medicine, pharmacy and law (Allen and Lyne 2006). There are few funded nursing studentships and the majority of published nursing research is self-funded (Rafferty, Newell and Traynor 2004). A 2001 task group found that research in nursing was under-funded, and skewed towards short-term projects rather than mainstream service evaluation (Higher Education Funding Council for England 2001). Historically nursing research has been characterised by small projects, limiting its ability to produce a nursing research strategy which could contribute to a comprehensive theoretical evidence-base (DH 2000b).

Despite these difficulties health visiting has been comparatively successful within nursing in establishing a body of knowledge (Lupton, North and Khan 2001), especially in comparison with comparable professions such as district nursing (Dingwall, Rafferty and Webster 1988, Symonds 1991). However, health visiting encounters a profound difficulty in demonstrating the effectiveness of preventive services, as a consequence of health promotion outcomes being ill-defined, long-term and difficult to measure by quantitative

means (Naidoo and Wills 2000). Health visitors have not been slow to propose solutions (Kelsey 1995, Campbell, Cowley and Buttigieg 1995, Cowley 1996), but alternative methods of evaluation gain little currency and health visiting continues to suffer from a perceived lack of evidence-base. This issue will be discussed in greater detail in section 2.6.6.

2.4.2 Centralised control of the NHS

At the beginning of its third term of office, the Thatcher government began to challenge the power of doctors within the NHS by excluding the medical profession from the discussion stage of all new health polices. This meant that doctors could not veto or amend at an early stage policy which threatened their interests, as had happened in the past (Klein 2001). This did not change the fact that medicine is still the pre-eminently powerful profession within the health service, but it paved the way for a changed relationship between the medical profession and the government. Increased emphasis on efficiency and effectiveness and the development of evaluation tools has laid the foundations for much closer management of professionals within the NHS (Baggott 2004). Annandale (2004) has described the reforms of the 1990s (such as introducing competition to the health service, increasing managerial control and devolving responsibility to the point of contact with clients), as seeking to enhance quality and cost-effectiveness by breaking the traditional grip of professionals over clinical decision-making.

Mrs. Thatcher's government was a watershed for the welfare state and public services in that it favoured private sector solutions, lower public spending and taxes, and a managerial approach to public services (Baggott 2004). It did not take account of vested interests such as the medical profession or the health service trade unions in the same way as previous governments had done. In Mrs. Thatcher's third term reform of the NHS began in earnest. The 1983 Griffiths report recommended that general managers, preferably recruited from outside the NHS, take responsibility for service performance

and management from regional to unit level. As a result of this report nurses lost the right to be managed exclusively by a member of their own profession, and lost their automatic representation on district management teams, representing a significant assault on their management role (Clay 1987). The internal market had a negative effect upon nurses, because lay managers exerted tighter control in attempts to reduce the costs of this major element of NHS expenditure (Baggott 2004).

Many of the reasons behind the reform of the child health surveillance programme stem from the paradigm shift which took place in British health policy in the 1990s (Allsop 1995). 'Working for patients' (Secretaries of State for Health 1989) had introduced the concept of the internal market, and of strengthened control of the periphery by the centre as a means of making management more efficient. The 1990 NHS and Community Care Act brought a form of internal market to the NHS, which was intended to mimic the workings of the external market by stimulating competition between rival providers of health services. The structural foundation of the reforms was the division between purchaser and provider functions. Salter (1995) has demonstrated how developing the internal market, plus incentives for a mixed economy of welfare in the NHS, was a method of addressing the historic problem of balancing the demands placed on the State and the supply of resources available to it. In the 1990s it appeared no longer acceptable to the public or the government to continue managing the imbalance by covert rationing of health services and increasing taxes. The internal NHS market has led to a focus on measurable outcomes as the most highly prized means of assessing the value and efficacy of services, and which has profound effects upon the way health professionals work and the nature of the services provided. Professionals must now justify their actions in terms of economy and corporate policy (Ruane 1997).

Under New Labour the move to extend further centralised control within the NHS continued. Performance measurement increased, with additional threats of central intervention if performance did not meet targets (Klein 2001). Working hand-in-hand with the clinical emphasis on evidence-based medicine, new organisations were developed to set and monitor standards, such as the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement. A series of exposés of failures in doctors' clinical performance allowed the Blair government to introduce changes in the regulation of the medical profession (Ham 2004). Following the Bristol enquiry into paediatric cardiac surgery, doctors were prepared to agree to a degree of supervision and monitoring to which they had never before been subjected. As a direct result of a series of exposures of professional tolerance of substandard practice the National Service Framework (NSFs) were implemented. These set out national service standards and key interventions for a particular medical condition or for a particular patient group (Talbot-Smith and Pollock 2006). The government agenda for the NHS now puts unprecedented weight upon evidence-based medicine and practice in the form of quality frameworks, standards and guidelines, and it is arguably the most influential idea behind current health service policy (Rafferty, Newell and Traynor 2004).

Baggott (2004) describes the strength of NSFs as setting explicit standards for services, but makes a number of critical points about the way that NSF policy translates into practice. Firstly, the NSF itself can be dominated by medical perspectives and represent a top-down approach to quality assurance. Secondly, the 'core service' framework of NSFs potentially contributes to greater rationing and targeting of services. Thirdly, he points out that the system of central guidelines supported by implementation measures is itself an untested intervention. While most people support greater efficiency in healthcare, it is not known what effects continuous evaluation, prioritisation on the basis of need and professional accountability

have when applied in practice. He suggests that such measures provide a justification for systems of performance management which focus only on what is measurable, and ignore intangibles which cannot be measured, such as professional good will. This may perversely have led to less accountability and trust within professional groups in the NHS. Lakhani (2001) considers that the focus on NSFs by PCTs can have the effect of distorting local priorities, and reducing 'buy in' by professionals.

Nurses and professions allied to medicine have also been required to follow national guidelines in their clinical practice, and thereby to submit to greater managerial control. There is some evidence that this has caused fewer problems for nurses than for doctors. Nurses are much more closely controlled by legislation than doctors, and are accustomed to working under conditions of negotiated autonomy, while remaining highly accountable for their work. Health care organisations now place great emphasis on nurses' and midwives' individual accountability (Annandale 2004). Edwards, Marshall and McLellan (2003) describe persistent conflict between doctors and health service managers as arising from conflicting beliefs about key aspects of the modernisation agenda (for instance the use of guidelines), the extent of professional accountability and the need to accept that all clinical decisions have resource implications. In an empirical study Degeling *et al* (2003 found that nurse managers were the professional group most supportive of modernisation, but that general managers and doctors failed to take into account the views of other professions, most notably nurse managers. The authors recommended that doctors and general managers engage more with nurses and allied health professionals when debating reform initiatives, but regretfully conclude that this recommendation is likely to be rejected as 'culturally difficult and destabilising to established positions of power' (p5, Degeling *et al* 2003).

2.4.3 Reforms of primary care

One of the ironies of current health policy is that while strenuous attempts have been made since 1990 to reduce the power of doctors, the powers of GPs within primary care and the wider health service have exponentially increased. The first reason for this is that UK policy on primary care in the 1980s was linked to the public health approach of the World Health Organisations 'Health for All by the year 2000', which advocated a primary care-led health service[27]. The Conservative government recognised the potential of primary care as a gatekeeper to secondary services, and thus supported moving GPs to a more central position in the NHS. However, primary care expenditure was difficult to control due to poor management practices and weak accountability, so while changing the balance of power between hospital and primary care services, in favour of the GPs, the government also sought to gain more control over their work (Webster 2002). This tension between central control and local autonomy is still being played out in the balance between national guidelines and local commissioning of health services.

The 1990 GP contract put increased pressure on GPs to offer a high level of patient service (Holliday 1995), and introduced measures to increase health promotion and preventive medicine in general practice (Baker and Hann 2001). While it had been previously accepted that 'a GP did what a GP did' (Zwanenberg 1991, p157) the new contract stipulated and gave financial incentives for work that should be done, including screening, immunisations, and child health surveillance. Child health surveillance (CHS) had never previously been considered the normally expected duty of a GP, but it was now an optional additional service. GPs could apply to the health authority to be added to the list of approved CHS providers. This served to shift CHS from the community clinics run by CMOs to GPs' surgeries, and contributed

[27] Caraher and McNab (1997, p105) have pointed out that in the UK primary care-led invariably means GP-led.

to the demise of the CMO post. Since the Court report it had been anticipated that GPs would be made responsible for child health surveillance, and while Butler (1989) acknowledged the claims of health visitors to CHS, he recognised that 'if the GPs had set their sights on surveillance…it was unlikely that health visitors could effectively outwit them' (Butler 1989, p100).

Many authors questioned whether GPs had adequate training or skills, in public health or child health, to deliver child health surveillance (Polnay and Pringle 1989, Marsh, Russell and Russell 1989, Stone and Campbell 1997), and there was some evidence from practice that many GPs did not do CHS well. In one region, Li and Logan (1996) found considerable inter-practitioner variability in screening practice, with some GPs not undertaking all the screening tests required by national or local policy, while others introduced screening programmes of uncertain benefit. Despite national guidelines setting out the criteria for acceptance, in practice acceptance of GPs on to CHS lists was not carried out consistently, leading to variation in quality of CHS provided (Evans, Maskrey and Nolan 1991). Many GPs continued to view CHS as the health visitor's responsibility (Marsh, Russell and Russell 1989, Gillam *et al* 1993). As health visitors were already providing much of child health surveillance, it was anticipated that it would be a shared exercise, like ante-natal care where GPs and midwives provide care together, but fees and allowances relate to GPs (Bain 1990). It had been planned that parents could have a choice between the GP service or the community child health service, but where GPs were not able to or did not choose to provide CHS, then premises and staff had to be provided by district health authorities to meet local need.

Following the unexpected success of GP fundholding under the Conservative government, the new Labour government further extended the power of GPs to manage commissioning of health care, reversing the historical balance of power between hospital and community services (Klein 2001). The Primary

Care Groups (PCGs), and the subsequent Primary Care Trusts (PCTs) introduced by the Labour government in 2002, consolidated the idea of the market principles underlying fundholding, and extended it to all GPs and all hospital and community services (Pollock 2005). Prior to Labour coming to power Salvage (1996) challenged the government to reconsider putting GPs at the centre of community health care. She accused the Labour Party of failing to perceive the differences between public health, primary health care and general practice, and questioned why GPs should be put in a position to run community services, when other members of the team had greater public health experience, skills and training (Salvage 1996). Despite PCGs being seen as an effective way of putting doctors, nurses and local communities at the forefront of managing local health care (Smith and Sheaff 2000), in practice nurses lost out to the GPs in gaining a place on PCG boards. Earlier guidance had stated that the board should not be dominated by one professional group, but after a wrangle for dominance, GPs were given the right to a protected majority of up to seven places and the Chair, while nurses had up to two places on the PCG board. The PCG Chair was appointed by local GPs without other stakeholder groups being consulted (Smith and Sheaff 2000).

In 2005 GP practice-based commissioning was introduced, which gave further responsibility and power to GP practices in commissioning services. GP service providers could hold the budgets and commission all medical services, including primary care, community health services (including health visitors and district nurses) and hospital care. Some commentators argue that this has formalized the requirement, always placed upon GPs within the NHS, to ensure that demand for services balances with the resources available. Rationing has always been acknowledged to be part of the NHS, though generally managed well away from public view and justified by doctors' clinical judgment (Salter 1998). First of all fundholding and now practice-based commissioning, have made rationing, or choosing how to

prioritise the allocation of resources, a more open issue (Klein 2001). Although rationing is always difficult in health care because it conflicts with medical ethics, trading off what is due to one patient against what is due to another (Smith and Morrissey 1994), long-term acceptance of this role and the financial rewards traditionally received by doctors ensure that this continues, with relatively little outside discussion (Wilmot 2003).

2.4.4 Health promotion and public health

The renewal of interest in health promotion as a health strategy began under Mrs Thatcher's government. The Alma Ata declaration (WHO 1978) had brought health promotion and public health to the international stage, and this influence began to spread within individual countries. Klein (2001) points out that it was unusual to see a Conservative government espousing the cause of health promotion, with its connotations of a 'nanny state' and limiting personal choice, but it seemed to provide an answer to several concerns of the time. Some diseases such as HIV/AIDs seemed controllable only by a public health approach, and there was the perennial problem of unlimited demand versus limited supply, to which health promotion appeared to offer a possible solution (Klein 2001). Health promotion suffered from the same problems as preventive health services in lacking a secure evidence-base for practice (Naidoo and Wills 2000), but this did not halt its rise as a driving force in health policy.

Webster (2002) detects a cynicism in the government's espousal of the new health promotion. By drawing on the new thinking of the World Health Organisation's 'Health for All by the Year 2000', policy documents such as 'Promoting Better Health' (Department of Health and Social Security 1987) could be presented in their most altruistic light:

> 'The design of this model ('Health for All') for the Developing World context made it also appealing to a Western government looking for a means to cut expenditure and

> legitimate its campaign to bring independent contractors under more effective regulation'(Webster 2002, p).

The new public health movement was based on a social, political and environmental approach that reflected the 19th century origins of public health (Johnson and Paton 2007). Klein (2001) points out that the new wave of governmental enthusiasm for public health limited itself to achievable targets, and did not suggest structural changes, such as income redistribution or reducing unemployment. It did, however, embody the principle that governments have a responsibility for the health of the population beyond health service provision, and a growing awareness of the potential role of medicine in producing health rather than treating disease.

It appeared that the new emphasis on public health would offer new opportunities to health visitors. Health visitors had continued to insist on the public health basis of their role, and the four principles of health visiting (Council for the Education and Training of Health Visitors 1977, Twinn and Cowley 1992), took a resolutely radical community development approach (Craig 2002)[28]. The part played by community nursing services in carrying out health needs assessment of practice populations, developing health promotion programmes, and reaching out to people not registered with a GP (such as homeless people and travellers, substance misusers and those who prefer to use A&E) was recognised and acknowledged in 'New World, New Opportunities' (NHS Executive 1993). However, despite the increasing use of health needs assessment as a means of identifying health needs at a local level, health visitors were not able to establish themselves on the NHS stage as skilled public health practitioners (Stone 1996). Unfortunately GPs did not see health visitors as being partners in providing health promotion for their

[28] The principles of health visiting are;

- to search for health needs
- to stimulate awareness of health needs
- to influence policies affecting health
- to facilitate health-enhancing activities

(Council for the Education and Training of Health Visitors 1977)

clients, but preferred to use practice nurses, who were often employed by themselves, were more clinically and task focused, and more accustomed to their work being directed by doctors (Baggott 2004). Incentives were provided for GPs to employ clinical nurses to improve the care of chronic health conditions (Derrett and Burke 2006) but health visitors continued to be among the most marginalised members of the primary healthcare team (Pearson and Jones 1994, McDonald, Langford and Boldero 1997).

Health visitors have continued to be mentioned in public health policy documents, particularly with regard to their family-centred public health role (Home Office 1998, DH 1999a, DH 2001). Lowenhoff (2004) identifies a tendency within policy to attempt to split the health visiting role into either a public health direction (working with groups and communities) or therapeutic work with individuals. Notwithstanding, a number of articles debated ways in which health visitors could practise and develop their public health role within the context of their wider work and their position within the primary healthcare team (Caraher and McNab 1997, Botes 1998, Malone *et al* 2003). Problems persisted in translating policy into practice. An empirical study revealed that nurse managers had varying interpretations of the public health role, with many regarding it as a marginal activity, which was not a legitimate part of nursing (Plews, Billingham and Rowe 2000). Hawksley, Carnwell and Callwood (2003) found many policy references to a public health role for nurses, but there were few reports of these approaches in any published accounts of health visiting practice. The public health role for nurses did not lead to links being forged with public health departments or to opportunities for health visitors to engage in joint working with other public health agencies. Molloy and Caraher (2000) found no evidences of public health nursing posts being classed as specialist public health posts, nor did they allow nurses to qualify for registration as public health specialists.

The barriers to nurses becoming involved in public health were examined in a report produced by the Standing Nursing and Midwifery Advisory Committee (1995) at the request of the chief nursing officer. This report noted that significant amounts of public health work were already being done by nurses, including health assessments, interventions for children and families, health promotion and community development. However, this work was generally not recognised, and, due to a lack of research, even well-established interventions remained unevaluated. Nurses were seen to be excluded from public health departments due to the lack of an identified role for nurses, combined with poor funding of public health training and undeveloped career pathways for non-medically trained practitioners (Standing Nursing and Midwifery Advisory Committee 1995). Lupton, North and Khan (2001) suggest that while health visiting, more than nursing, has managed 'to develop a body of knowledge and a therapeutic direction independent of mainstream medicine' (Lupton, North and Khan 2001, p146), this has not been in the direction of the new public health.

2.4.5 The inequalities agenda

Under the new Labour government, in common with other European welfare states, health inequalities came to the forefront of policy-making (Acheson 1998, van Oorschot 2002)[29]. Since the publication of the Black Report (1980) inequalities in health had been largely absent from British political debate, but New Labour brought them back to the public agenda (Davidson, Hunt and Kitzinger 2003). While the health of the whole population has improved since the 1970s, the poorest sectors of society have not caught up with the more privileged. (Marmot 2004). Indeed it is now recognised that policies which seek to improve the health of the whole population can increase health

[29]Income inequality increased dramatically from 1985, due to increasing differences between earned and private income, the abandonment of the link between benefit levels and the average wage, and the tendency of families to polarise into work-rich and work-poor households. Whereas in 1979 10% of children lived in households with an income of less than half the national average, by 1991-1992 one third of children lived in such households (Bilton 1999).

inequalities. With a population–wide improvement in health, the gap between the health status of rich and poor can actually increase (Kelly *et al* 2007).

There are two ways of responding to the seemingly intractable dilemma of worse health among the poorer segments of society against a background of population-wide health improvement (Graham and Kelly 2004). The first is to link health policy to the social exclusion agenda and direct services to those in the worst socio-economic circumstances, and the second is to take a broader gradient of health status, accepting that services need to be directed as those with greater need, not just the socially excluded. Current public health policy is directed at improving the health of the population by raising the health status of those with the poorest health, in preference to risking increasing health inequalities by raising the health status of all (Graham and Kelly 2004). This has added weight to the policy impetus to improve the health of the most disadvantaged, rather than seeking to improve the health of the whole population.

Joint working between the NHS and other agencies, was increasingly seen as the key to addressing the roots of ill health, supported by coordinated policies across several governmental departments (Klein 2001). With the explicit recognition that social and economic factors are the principal determinants of health, medical science began to lose its status as the dominant intellectual framework in maintaining and improving the health of the population. As a result, health services ceased to have a monopoly on providing public health initiatives. Initiatives such as Sure Start and the Children's Centres stepped on health visitors' traditional territory of family support and practical health promotion initiatives (Clarke 2006). To some extent, health visitors were able to capitalize on these opportunities to engage in partnership working at a local level (by joint working with Sure Start or taking the lead as programme managers). However they were not an integral part of these local authority-led initiatives. Local Sure Starts had

health targets to meet, but centres were staffed by child care workers and nursery nurses, rather than health-trained practitioners.

One example of these approaches to prevention is the Family Nurse Partnership Programme, which has been adapted from the work of Olds (2006) in the USA. This scheme provides targeted home visiting (usually by health visitors or midwives) to the most disadvantaged children and families (Cabinet Office 2006). Research is currently underway to compare the effectiveness of the FNP programme with routine health visiting. Targeted interventions of this kind tie in well with the notion of evidenced-based policy, since interventions directed at specific sectors of the population lend themselves more easily to monitoring and evaluation and are more easily tested against targeted outcomes (Graham and Kelly 2004, Robinson 1998).

2.4.6 Changing relationships between parents, children and the State

The UN Convention on the Rights of the Child was passed in 1989, and ratified by the UK in 1991. In some aspects the UN Convention took a liberationist view, in which the child's interests are seen as separate from those of its parents, which some States saw as a threat to parents' rights of autonomy over their children (Harding 1999). The UN Convention had a strong influence on the 1989 Children Act, which changed the relationship between health agencies and local authorities in providing children's services. For the first time social services authorities had to take responsibility for identifying and supporting 'children in need'. Health services were to focus their resources more strategically, rather than providing universal services, while local authority services were to provide a broader range of family support services, rather than the traditional highly targeted family support services. In this way services for children were to be 'needs-led' rather than service-driven (Audit Commission 1994). Unlike the UN Convention, the UK 1989 Children Act, while emphasising the importance of State agencies working in partnership with parents, served to strengthen the

focus of the law upon the family rather than on the child (Hendrick 2003). A basic aim of the Act was to keep compulsory intervention in families to a minimum (Hendrick 2003). Even in the area of health Mayall (1996) saw the interests of children being subordinated to those of parents, as under the Act parents retain to the right to define children's best interests.

'Every Child Matters' (DH 2003a) has set out the policy direction of welfare services for children. Health is one of five main domains of children's well-being[30], which are set out in the report. The Children Act of 2004 formed the legislative basis for the 'Every Child Matters' programme. This Act called upon local authorities to work in partnership with agencies, such as PCTs, to improve children's well-being, and made safeguarding and promoting the welfare of children a duty of PCTs. Key implications for health organisations included increasing the emphasis on early identification and intervention, strengthening health promotion in local communities (for instance in promoting healthy lifestyles) and targeting resources to the neediest communities (DH 2004b). The new approach to children's health as exemplified by 'Every Child Matters' (DH 2003a), represents a radical move away from the traditional focus of children's preventive services on the universal and developmental needs of children (Bradbury-Jones and Bates 2005). The current policy approach is targeted to the most disadvantaged, promotes intervention to prevent social exclusion, and does not seek to provide an equally comprehensive service for all children.

Increased targeting had been proposed for health visiting prior to 'Every Child Matters', even from within the profession. A landmark paper by Shirley Goodwin, then general secretary of the Health Visitors' Association (HVA), described health visiting as 'trapped' in the traditional home visiting model, and proposed re-focusing health visiting towards targeted, measurable

[30] These are; 'Be healthy', 'Stay safe', 'Enjoy and achieve', 'Make a positive contribution' and 'Achieve economic well-being' (DH 2003a).

interventions with defined client groups (Goodwin 1988). The 1994 Audit Commission report 'Seen but not heard', challenged health visitors to direct their services more towards the most disadvantaged. Somewhat anachronistically, this report accused health visitors of duplicating the work of Children's Centres, while also criticising the profession for not being able to produce sufficiently tangible evidence of effectiveness (Audit Commission 1994). In 'Reaching Out: an action plan on social exclusion' (Cabinet Office 2006), it was claimed that families with the highest incomes are more likely to get support from health visitors than lower income groups. This charge has been strenuously denied by health visitors, arguing that it is a misrepresentation of the figures, but has not been withdrawn. Strong arguments have been made that the origins and development of health visiting have inevitably led to a service which operates only at a universal level; and that to introduce targeting is to risk alienating service users (Robinson 1998).

A final facet of the changing relationship between the family and the State is the consumerist focus of much health policy. Johnson and Paton (2007) have described the ongoing tension in health care policy between the 'democratic approach', which seeks to challenge the dominant structural interests in health by involving service users in policy-making, and the 'consumerist approach'. The consumerist approach is related to advancing efficiency, effectiveness and cost-effectiveness, but leaves decision-making with policy-makers and health professionals. As a consequence of this process individuals rather than communities define collective interests, creating a real risk of consumer expectations increasing beyond the capacity of services to deliver (Johnson and Paton 2007). Beresford (2002) defines the consumerist approach as being managerialist in purpose, without any commitment to personal and political empowerment. Within this approach the patient is re-conceptualised as a 'consumer' who is empowered to make health choices, including being able to choose between a variety of health service providers

(Annandale 2004). Families are cast as consumers of 'welfare goods' such as education and health, and encouraged to make choices on behalf of their children (Crinson 1998). As yet there has been little discussion of how this consumer paradigm works in relation to preventive health services for children, where the child is reliant upon its parents for access to services designed to maintain and improve life-long health.

2.4.7 The decline of health visiting

The period from 1989 to 2008 has been one of struggle for health visitors, both to maintain their role and to establish the future direction of the profession. Part of the task of a profession is to stake out and maintain control over a professional territory (Witz 1992), and health visiting has encountered increasing difficulties in managing this task successfully. This is partly because health visiting has, for the first time, come under close scrutiny by senior NHS management as the prime workforce of PCTs (Lupton, North and Khan 2001). This has meant that health visiting has to defend its role in terms of the evidence base for activities and evaluation of outcomes. In addition health visitors have lost allies during this period, notably clinical medical officers (CMOs) whose role disappeared in the 1990s. While to some extent health visitors have succeeded in making new alliances, as shown by their involvement in Sure Start (Department for Education and Employment 1999) and the targeted Family Nurse Partnership programme (Cabinet Office 2006), they have not succeeded in attracting champions for universal health visiting. Most significantly they have not been able to overcome the historical barriers between general practice and health visiting.

It is hard to conceive of a service more unattractive in the early 21st century NHS than health visiting. With its universal approach, loose aims, and difficult to measure outcomes it may appear ripe for being eased out by market forces, which cannot see why it is still in existence. Welshman (1997)

considered that by 1974 the decline in infant mortality, coupled with the rise in general practice and the expansion of social work, had undermined any rationale for health visiting work. An oft-quoted and notable denunciation of health visiting as an outmoded service was made by the 'Anti-Rationing Group' in the Health Service Journal (Roberts *et al* 1996). Roberts, a professor of epidemiology and 16 colleagues (mainly medical consultants and GPs) launched a broadside attack on health visiting, claiming that it could show no evidence of measurable benefit. It was suggested that NHS managers should demonstrate their dedication to effectiveness and cost-effectiveness, by redirecting health visitors to clinical nursing work[31]. Similar disrespect for the profession was exhibited by Sir Al Aynsley-Green, the first Children's Commissioner, who alluded to health visitors as 'old dinosaurs' who sorely needed to prove the effectiveness of their work[32] (Carlisle 2003), and on a smaller scale in Symonds' (1997) primary care research which described GPs making clear the power lines by openly and unashamedly remarking to the researcher that they had no idea what health visitors did.

Health visitors have frequently been called upon to demonstrate evidence of effectiveness for health visiting. In 2000 a Health Technology Assessment was carried out of health visiting - the first time a whole profession has been evaluated in this way (Robinson 2000, Elkan *et al* 2000a[33]). This systematic review found evidence, mainly from the USA, that home visiting is associated with improvements in parenting and the home environment, children's behavioural problems and intellectual development, the detection and management of post-natal depression, the quality of social support for mothers and improved breastfeeding rates, as well as a reduction in accidental injury and a safer home environment (Elkan *et al* 2000a). When

[31] It was noted with interest in this article that, although one of many occupational groups in the NHS with an inadequate evidence base, health visitors were unusual in openly admitting it.
[32] '…many wonderful student health visitors…find themselves challenged…by what they call the old dinosaurs who prevent them translating what they have learnt into practice. It's not me saying this, it's them' (quoted in Carlisle 2003, p202).
[33] Elsewhere the authors have written vehemently about their dislike of the scientific and reductive term 'health technology' to describe health visiting practice (Elkan *et al* 2000b).

the British studies of health visiting were examined (which generally did not meet the inclusion criteria for the meta-analysis because they were too small), questions were raised, such as 'Is the health visitor a statutory agent or a family friend?', 'What is the evidence for professional versus non-professional home visiting?', 'Should health visiting be a universal or a targeted service?', which could only be answered by more extensive research into British health visiting. The report described indications from existing research that professional home visiting is required for complex difficulties, and that interventions targeted to a narrow range of outcomes are less effective than broader, family-based interventions (Elkan *et al* 2000a), thus supporting the UK model of universal professional health visiting.

Evidence from research did not stop severe reductions of the health visiting services in practice. In 1999 two documents were published which gave accounts of planned 'disinvestments' in health visiting, carried out by health authorities to make financial savings. In Cambridge savings were made by integrating health visiting and school nursing teams, so that practitioners no longer maintained their distinct roles (Cowley 1999). Preventive work, such as well baby clinics and school drop-in clinics were replaced with a targeted service for those with identified needs. In response to the 'disinvestment' in health visiting in Croydon, the Community Health Council commissioned a report due to serious concerns about the effect of the service cuts upon children (Cowley and Houston 1999). Again services had been reduced to providing a limited core service, with a single post-natal home visit. In the event the financial savings made were greater than those required, as within four months of the 'disinvestment' many staff left the service, and it was impossible to recruit sufficient new staff to replace them. The authors noted that the health authority failed to understand the social and preventive aspects of the health visiting role, and viewed community nurses as clinicians who delivered specific treatments to individuals with identified health needs (Cowley and Houston 1999).

In a climate of widespread NHS budget deficits leading to rising nurse redundancies, vacancy freezes, poor staffing levels and lack of money to buy basic equipment (Royal College of Nursing 2007), there have continued to be cuts to health visiting services. In June 2006 Amicus[34] warned that community services were being seen as 'soft' or invisible targets for trusts operating under budget deficits (Brown 2006). In several areas around the country the CPHVA protested against proposed cuts in posts, vacancy freezes, and in one case plans for secretaries to weigh babies (Unite/CPHVA 2008). Not only were health visitors at risk of losing their jobs, but the profession itself seemed to be shrinking. The Community Practitioner (2006) reported total numbers of health visitors were at their lowest level since 1994. Among those that remained, nearly one-fifth of health visitors were over 55 years old. Cuts to training budgets meant that very few new recruits were coming into the service, and in many areas no new health visitors were trained at all. In 2007 the CPHVA used the Freedom of Information Act to force universities and colleges to release figures which showed a 40% drop in health visitor training places (Noble 2007). To cap it all, in 2004 health visiting had lost its separate registration as a branch of nursing, and became subsumed within nursing for professional registration purposes (Rowe 2003, Cowley 2002, Pearson 2002). Health visiting was thus at a low ebb of professional status and confidence, and not well placed to defend its universal, child-focused work with families.

2.5 Conclusion

In this chapter I have demonstrated a variety of reasons why the Hall reports achieved their dominance in deciding the course of children's preventive

[34] The Community Practitioners and Health Visitors' Association is a section of the Trades Union Organisation Unite, formerly called Amicus.

health services, and so successfully influencing UK policy. The reports 'fitted in' very well with such current ideas as imposing a standard upon professional practice, ensuring the practice is based upon quantitative research evidence, shedding practices which cannot be proved to be effective, focusing on health inequalities and providing targeted rather than universal services. What this has meant in practice is that the routine universal service offered by health visitors has been radically curtailed. It is likely that this was a by-product rather than a central intention of the venture, but it resulted from a lack of recognition that less contact with children and parents will have an impact upon the service that health visitors offer. There seems to be an assumption that such activities as creating an empathic trusting relationship with parents (Hall and Elliman 2003), providing support for parents (Hall 1996), following up referrals from other agencies (Hall and Elliman 2003) and preventing child abuse (Hall and Elliman 2003), which health visitors continue to be expected to engage in, will happen irrespective of reductions to the core programme. The following chapter presents the methodology of my empirical research study. This was designed to investigate the impact of the changes to the CHPP on health visitors' practice.

Chapter 3
Research Methods

In this chapter I shall discuss the research methodology of the empirical research project. The project used a two-part methodology. Firstly, a survey was carried out of the child health promotion programme practice, and attitudes to policy, of a large sample of health visitors in the UK. Secondly, a nested interview study explored in greater depth the reasons why health visitors practised child health promotion as they did. The survey is referred to as Phase I of the study and the nested interview study as Phase II. Below I shall outline the aims of the study, explain why these methodologies were chosen to investigate the research questions and consider the relationships between the two phases of the overall study. The methods of each phase of the study are then presented in detail.

3.1 Empirical research aims

The aims of the research were:

- To examine the extent to which post-1989 national policy changes to the national child health promotion programme (CHPP), in particular the move to an increasingly targeted service, are reflected in local policy and practice across the UK.
- To explore the views of health visitors on the effects of increased targeting of the CHPP on their practice
- To explore the context in which changes to the CHPP have been implemented by health visitors

Although the first research aim is more closely related to the survey (Phase I), and the second to the interview study (Phase II), both research aims apply to both phases of the study. The project was designed to yield a broad picture of CHPP practice in the UK, while also looking in more detail at the

views and attitudes of a smaller sample of participants. In this way it was anticipated that authoritative statements could be made about what child health promotion work is carried out by health visitors, accompanied by an insight into what factors contribute to health visitors carrying out the CHPP in the way that they do.

3.2 Rationale for methodology

The study was designed with the intention of choosing the best methods to meet the aims of the research. Below is given a rationale for the methods used in each phase of the study and how these contribute to the study overall.

3.2.1 Why use survey methodology?

Quantitative and qualitative research differ in terms of philosophical assumptions, methods of data collection and techniques of data analysis (Parahoo 1997). Porter and Carter (2000) give a simple definition of quantitative research;

> 'Quantitative research is a formal, objective, systematic process for obtaining quantifiable information about the world, presented in numerical form and analysed through the use of statistics. It is used to describe and test relationships and to examine cause-and-effect relationships' (Porter and Carter 2000, p19)

Some would argue with some elements of this definition - the section below on qualitative data analysis will claim that the processes used are as systematic as those used for processing quantitative data - but overall there is agreement that quantitative research involves measurement, numbers and statistical analysis of the relationship between variables.

Quantitative research uses probability samples in order to provide valid evidence about the phenomenon being studied. Probability samples are used when the researcher aims to obtain a sample which is reliably representative of the wider study population (Hek, Judd and Moule 2002). By gathering

information from a large random sample of participants across the UK the intention was to produce findings which had a claim to be representative of the whole UK health visitor population, thus giving a national overview of health visitors' practice. A large sample was needed to permit statistically significant discriminatory variables to be determined, and to draw statistical inference with the required precision (Ritchie, Lewis and Elam 2003).

The quantitative research approach lends itself to the investigation of subjects where there is pre-existing knowledge. This knowledge allows a standardised data collection method to be used, for instance a survey questionnaire (Bowling 1997). Pre-existing knowledge about the CHPP was plentiful and included the national programme laid out in the National Service Framework for Children (DH 2004a), the Hall reports and comment on the process of change in many academic articles, from a variety of academic and professional sources. As a practising health visitor I was familiar with the issues of CHPP implementation, and have some prior understanding of what elements of content and structure are commonly seen as problematic by practitioners. This background knowledge of policy and practice, and the context of policy change, enabled me to devise the data collection tool.

The survey method was chosen as the most feasible and cost-effective way of canvassing the views of a large numbers of health visitors across the UK. Surveys involve systematic questioning to yield data which aims to be representative of the population being researched (Sapsford 1999). By means of a questionnaire all participants are asked the questions to which the researcher seeks answers. The aim is to achieve standardisation by getting consistent answers to consistent questions. Findings can be considered reliable if the sample is representative of the study population and the data obtained are standardised (May 1997). There is no scope for participants to introduce new ideas within a survey as the questions are pre-set by the researcher, but an opportunity can be offered for non-standardised

response by giving space for free text comments. Findings from phase I of the project were used to develop the design of the subsequent qualitative study.

Survey methodology has previously been used successfully to investigate child health practitioners' views on service changes. Butler (1997a and 1997b) surveyed the views of a variety of child health surveillance providers and NHS managers on the impact of the publication of the first two editions of 'Health for all Children' (Hall 1989a and Hall 1991), the establishment of a new contract for GPs and the creation of the internal NHS market on preventive services for children. Response rate was high among health visitors (79% of a one-in-seven sample) suggesting that this group are motivated to take part in research which directly affects their practice. Butler considered his methodology was successful in providing breadth of coverage and representative findings. However, he suggested that a limitation of his study was that the data collected was confined to perceptions and opinions rather than offering an objective account (Butler 1997a). I aim to redress some of the acknowledged limitations of Butler's study by asking specific questions about the local prescribed programme, which means that the survey will reflect local policy on child health promotion (as reported by health visitors) as well as exploring the practice and views of health visitors. However, it must be acknowledged that a survey inevitably involves asking respondents for reports on their behaviour, beliefs and attitudes (Marsh 1979), and there may be vital differences between what is reported in the survey and actual behaviour.

3.2.2 Why do interviews?

The survey methodology, while highly effective in showing the variety of practice in the UK, did not shed light on the reasons why practice diverges from national policy. Qualitative methodology was therefore used to investigate the issues raised in the national survey, particularly to examine in

greater depth the relationship between the actions of individuals and the dictates of policy. The ability of the qualitative approach to allow participants to discuss the subject 'on their own terms' was an important factor in using the chosen methodology.

A qualitative approach was taken as best suited to the aim of exploring views in an area where there is a complex interrelationship between policy and practice. Barbour (2008) describes the peculiar contribution of qualitative research as being its ability to examine and make visible the relationship between variables. While quantitative research answers questions such as, 'How many?', and 'What is the strength of the relationship between variables?', it cannot provide an understanding of how these statistics are affected by social processes. Qualitative research does this by exploring the context within which social actors operate. This is particularly important when looking at how changes come about within a certain social and political context:

> 'Qualitative research is particularly well suited to studying context …[and] also excels at illuminating process, whether this is organisational change or individual decision-making, since it allows us to examine how changes affect daily procedures and interactions. This may lead to us uncovering unintended as well as intended consequences of the new arrangements.' (Barbour 2008, p13).

The free text comments gave an indication of some unintended consequences of CHPP policy reform, and the interviews allowed further exploration of this issue. The slant of interview questions was towards exploring both the reasons for divergence of practice from national policy, and the context in which the policy change was taking place.

Whereas the survey required a large sample, here a small sample was needed to permit close examination of health visitors' views. For a qualitative study a sample is needed which is large enough to permit a range of views, but sufficiently small to permit in-depth analysis and detailed exploration of

the data gathered. Small samples do justice to the richness of the data, and make feasible the intensive analytical work required of the qualitative researcher (Ritchie, Lewis and Elam 2003). It is not the purpose of qualitative research to produce findings which are representative of the entire study population, but to yield data which is highly contextual and embedded within respondents' perceived reality.

Interviews are suited to the exploration of complex and subtle phenomena, when the researcher wishes to gain insights into people's opinions, feelings, experiences and emotions (Denscombe 2007). An interview allows an insight into the individual's personal perspective, which deepens understanding of the meaning of the research phenomenon (Lewis 2003). Semi-structured interviews have pre-determined questions or topics which structure the interview, but interviewers have the freedom to digress and probe beyond the answers to standardised questions (Berg 1995). The ability to probe more deeply into respondents' answers was an important consideration when interviewees may be unclear about the relationship between policy and their own practice. Because interviews were semi-structured, interviewees were free to talk more about areas which were relevant to them, while broadly keeping within the subject area of the study.

Semi-structured interviews have previously been used to explore the views and attitudes of health visitors, often concerning 'taken for granted' aspects of their role, such as identifying clients' needs (e.g. Chalmers 1993, and Newland and Cowley 2003). This method has not so far been used to explore why health visitors practise child health promotion as they do, and how individual practice relates to policy on CHPP. The research that has been done on the child health promotion programme tends to be focused on effectiveness, rather than attempting to understand health visitors' standpoint using a qualitative approach.

3.2.3 Why use a mixed methods approach?

The study design incorporates both quantitative and qualitative methodologies, with the aim of each illuminating the other and adding to the understanding of the research question. Both research methods relied on the responses of health visitors, and their interpretation and understanding of the reforms that had taken place and the effect this had had on their daily work with clients. Both the survey and the interviews sought to discover how health visitors practised and also their views on the reform of the CHPP.

Mixed methods were used to provide a more complete picture of current child health promotion practice and the context within which it is carried out. The aim of combining methods was to gain a picture of what CHPP health visitors were practising nationally, and then to set this overall view within a more detailed and closer examination of the context in which changes had happened. Mixed methods are noted for their ability to provide a highly nuanced picture of the phenomenon under investigation, with the potential to influence policy and practice (Dixon-Woods *et al* 2005). However, the use of mixed methods does not necessarily in itself provide these multi-dimensional insights; instead it is important for the researcher to have a rationale for the particular combination of methods and to be able to demonstrate how the choice of methods contributes to a more subtle, complex and reflexive picture of the subject of study (Barbour 2008).

The findings from each phase of the study were not intended to replicate each other, but to provide a different perspective on the issue. In this way the findings are used in a complementary way to provide a picture of the phenomenon from two different aspects. Ritchie (2003) suggests;

> 'The purpose of interlocking qualitative and quantitative data is to achieve an extended understanding that neither method alone can offer. It is then up to the researcher to explain why the data and their 'meaning' is different.' (Ritchie 2003, p43)

In one sense in combining quantitative and qualitative methodologies I have followed a highly traditional epistemology in which a qualitative study gives 'added value' to the more rigorous and reliable quantitative findings. The large survey aimed to generate knowledge and data which could be influential in shaping opinion about the practice of the CHPP in the UK by establishing whether health visitors' CHPP practice is homogeneous or diverse and the reasons why practice may differ from policy. In seeking to produce reliable, representative data, I followed the dominant medical model of healthcare research, which aims to use a methodology high on the hierarchy of evidence in order to produce 'facts' which can be used to influence practice in healthcare. The nested qualitative study was then used in a complementary way to add richness and depth to the survey findings, to 'explain' areas where the survey had raised questions, and perhaps to 'fill in gaps' where the survey failed to give a sufficiently full picture. From a rigidly logical positivist standpoint the qualitative study could be seen as a junior partner to quantitative methods (Murphy *et al* 1998).

This idea of the relationship between the two phases of the study was not borne out in practice. While the qualitative study may have been intended to fill in the gaps from the survey, for instance adding to understanding of why health visitors' practice diverges from policy, it did not solely do this. Instead the qualitative study proved to be richly productive of new ideas about the impact of policy change and the policy-practice gap. New areas of study were identified including the way on which policies aimed at different sectors of the health service can 'work against each other' to produce new and unintended influences upon practice. In this way, the qualitative findings went far beyond their original aim of filling in an existing picture, and instead created a broader perspective of far greater complexity. The interview study did not play a subordinate role to the survey findings, but stood alone in depicting the effect of the CHPP reforms upon health visitors and their clients. In the following accounts of the implementation of the two

methodologies I shall challenge the assumption that the survey findings have a greater validity than those from the in-depth qualitative study.

3.3 Phase 1: the survey

3.3.1 Design

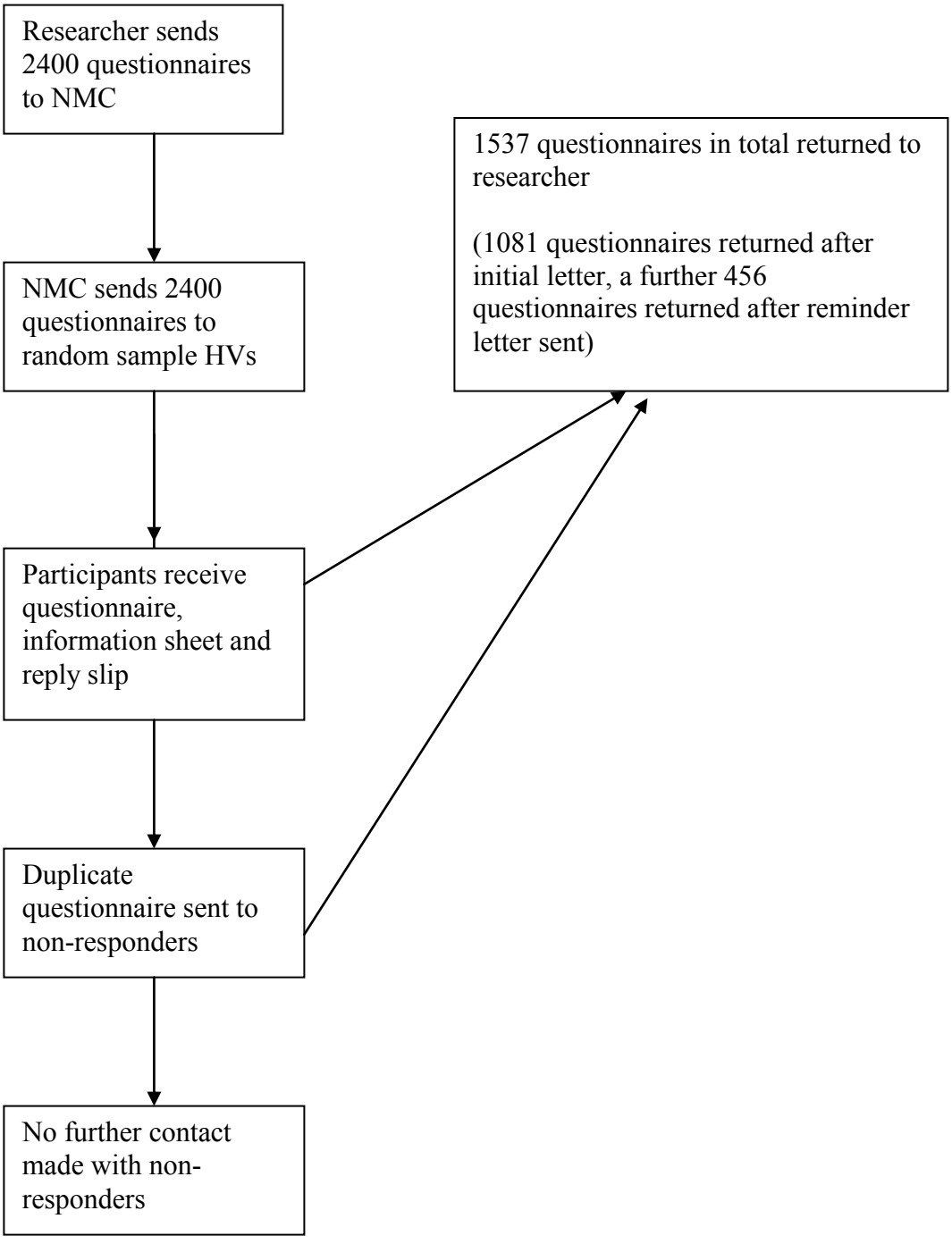
In July 2005 a postal questionnaire was sent to a random 10% sample of health visitors (n= 2400) registered with the Nursing and Midwifery Council (NMC). The questionnaire was targeted at health visitors who were involved in delivering the child health promotion programme, either as a practitioner or a manager. With the questionnaire, potential respondents received an explanatory letter/information sheet and a reply slip (to be completed if respondents wanted to be entered for a prize draw and/or to receive a summary of research findings). These are contained in appendices 3.1-3.3. Boynton (2004) has recommended that in order to maximise response rate to a postal questionnaire it should be clearly designed and laid out, incentives should be offered for completion, aims clearly explained and a stamped addressed envelope included. All these steps were followed.

The Nursing and Midwifery Council (NMC) is the regulatory body for all health visitors practising in the UK. Registration with the NMC is a precondition of working as a nurse, health visitor or midwife in the UK; re-registration is carried out on a three yearly basis. Although health visitors were moved to the specialist community public health nurse part of the register in August 2004, the NMC were able to identify which nurses on part three of the register were health visitors (England, Wales and Northern Ireland) and family health nurses (Scotland). This meant that the research information was not sent to other nurses on part three of the register who were not health visitors or family health nurses.

The initial contact resulted in a 45% response rate (n= 1081). All potential participants who did not return a questionnaire to the researcher were sent a reminder letter and duplicate copy of the questionnaire. This was originally intended to be one month after first mailing but, due to the need to find more funding to pay postage, the reminder questionnaire was finally sent out in early October 2005. The long delay between sending out the first and second questionnaire did not appear to adversely influence respondents, as response to the reminder was high. The response rate increased to 64% overall (n=1537) after this one postal reminder. It is probable that an influential factor in the final high response rate was that the subject was of interest to participants (Edwards *et al* 2002). The reminder letter is shown in appendix 3.4.

Figure 3.1 below shows how the questionnaires were distributed and the numbers which were returned.

Figure 3.1: FLOW CHART OF QUESTIONNAIRE DISTRIBUTION & RESPONSE



Key: NMC = Nursing and Midwifery Council

Not all returned questionnaires could be included in the analysis. Some questionnaires were returned blank (n = 12), and therefore excluded. The main reason for exclusion from analysis was that potential respondents were no longer practising as a health visitor/family health nurse engaged in delivering the child health promotion programme. After questionnaires were excluded from respondents who were not currently practising as a health visitor, health visitor manager or other early years health practitioner, 1043 questionnaires remained for analysis. The process of deciding which questionnaires to include is discussed more fully under data analysis.

3.3.2 Participants

The sampling frame, or 'list of the population from which the sample is to be drawn' (Sapsford 1999, p80), was all health visitors or family health nurses registered with the Nursing and Midwifery Council. The choice of an unbiased sample from this sampling frame was crucial in meeting the aim of the survey to provide a representative picture of CHP policy and health visitors practice across the UK. Sampling techniques were carefully chosen to increase confidence that the sample was not biased (de Vaus 1996). To obtain an unbiased sample all health visitors needed to have an equal chance of being in the sample.

Random sampling was carried out by the NMC on behalf of the researcher using number tables (Sapsford 1999). This size of the sample was chosen to produce adequate confidence intervals and ensure participants were randomly distributed around the UK. Once the sample was chosen all efforts were made to maximise the response rate, to ensure that respondents are not atypical of the sample as a whole. Ideally contact would have been made with non-respondents to ascertain whether they differed from respondents in any significant respects. However, this was impossible to do because the NHS Ethics Committee stipulated that the researcher should not have access to the participants' names and addresses.

In order to limit the sample to health visitors who were currently working with pre-school children as a practitioner or a manager, the first page of the questionnaire requested health visitors who did not meet the inclusion criteria to state their role and return the blank questionnaire to the researcher. Eligible health visitors, who did not choose to take part in the study, were asked to return the questionnaire to the researcher in the enclosed pre-paid envelope stating the reason for non-completion (preliminary questions 1 & 2). In this way it was intended that only practising health visitors would take part in the survey and the reasons for non-completion of the questionnaire would be known. It was possible to identify non-respondents because questionnaires were labelled with a unique reference number (URN) provided by the NMC to correspond with the names on the database.

3.3.3 Ethical considerations

A favourable ethical opinion was obtained from a National Health Service Multi-Centre Research Ethics Committee and the Departmental Ethical Committee of the School for Policy Studies, University of Bristol. In order to maintain confidentiality, the data base provided by the NMC was not directly seen by the researcher, and mailings to potential participants were sent out by a data management company. A formal consent slip was not required because completing a questionnaire demonstrates consent.

The NHS ethics committee had some concerns about the prize draw as an incentive for participation. Their concern was that procedures in making the prize draw would not be sufficiently stringent to meet the gaming laws, rather than considering that participation in a prize draw would unduly influence participants to take part in the study. In offering a reward to take part in the study, it could be said that I have unduly influenced participation. Barbour (2008) discusses how even such small incentives as this, have been given almost undue attention in research literature, and compares the taken-for-granted assumption that professionals will be reimbursed for assisting with

research, while research participants are usually expected to give their time for free. In this study the reward was very small (potentially winning some vouchers) and could be seen as token of thanks for taking part, rather than an incentive to complete the questionnaire. It was not necessary to complete the questionnaire in order to be entered in to the prize draw. A systematic review of the literature showed that the odds of response are almost doubled when a monetary incentive is used (Edwards *et al* 2002).

3.3.4 Validity

A large random sample was sought to lend credence to the findings being considered indicative of the views and practice of the target population as a whole. External validity would have been strengthened if it had been possible to discover whether non-respondents differed from respondents in any significant respects. Because it was not known whether non-respondents were more likely to be non-practising, or whether there was another reason for their non-response which made their views likely to differ from respondents, this potentially limits the ability to generalise from this study.

Perhaps the main limitation of the study was that not all questions were equally relevant to all the types of health visitors who were invited to respond. A flaw of the study design was that the questionnaire was fundamentally designed to elicit the responses of practising health visitors who were currently engaged in CHPP practice. Many 'other practitioners' such as Sure Start health visitors and practice nurses were not carrying out routine CHPP contacts with pre-school children, and managers were in the position of reporting the practice of those they managed. This did not emerge as a problem during piloting of the questionnaire (some managers were included in the pilot groups), but is likely to have influenced the capacity of some respondents to answer all questions.

A further issue relating to validity was my known identity as a health visitor, which may have influenced response to some questions. The opening paragraph of the survey contains an appeal to respondents to take part in the research because of the need to speak out about issues affecting 'our profession', thus reinforcing that I am health visitor. Although I endeavoured to make the language of the questionnaire neutral, it may have been apparent to some interviewees that I was working from an ideology of it being beneficial for health visitors to know families well with routine CHPP contacts as a useful part of this. Even though a survey is a quantitative methodology and aims to use a measure that is standardised, it should be remembered that 'questions are live communications and different questions will convey different intentions of what it is that that the researcher wants to the respondent' (Marsh 1979, p97). Marsh counsels;

> 'We must not confuse an impossible attempt to achieve 'absolute truth' through asking unbiased questions, with the aim of being objective in our quest for truth, through trying to be as rigorous as possible in the way in which we draw conclusions from observations we make about the world, what people say and how they behave.' (Marsh 1979, p101)

3.3.5 Data collection

As no previous questionnaire on this topic was found, questions were devised by the researcher to explore local policy on CHPP, and how health visitors practise within these guidelines. General rules on compiling a questionnaire, such as those given in May (1997) and Blaxter, Hughes and Tight (1996), were followed. The questionnaire, although not validated, was designed to collect data in a standardised way. In designing the questionnaire I used my experience as a practising health visitor, combined with knowledge of current debates in the child health community and evidence from a review of published literature. In addition, advisers from the local NHS Research and Development Unit made comments about the

questionnaire at various draft stages of composition, as well as academic supervisors.

The questionnaire was piloted using a volunteer group of 13 practising health visitors and two health visitor managers, and subsequently revised according to feedback on content, relevance to practice and ease of comprehension. After completing the pilot draft of the questionnaire, each respondent was questioned about the relevance and comprehensibility of the questions. Pilot study comments mainly focused around difficulties in attempting to define how often contacts took place. Whereas the last Hall report (Hall and Elliman 2003) and the National Framework for Children (DH 2004a) are very specific about the age at which routine visits end and targeting begins, health visitors taking part in the pilot did not describe their practice as being so clear cut. Visits were made 'around' certain ages, rather than at defined time points, and according to the health visitor's views on the needs of the family. Because one of the aims of the questionnaire is to ascertain how often health visitors are making contact with children and at what ages, these questions about the make-up of the programme, remained, but additional alternative responses were offered.

The questionnaire (see appendix 3.1) begins with the less contentious questions which require factual information about practice. The questionnaire specifically asks about the local PCT's child health promotion programme, whether it exists, if and when it was revised and whether there has been a move away from universal visiting up to school entry towards targeted visiting from a predetermined age point. Most questions focused on the health visitor's own practice in terms of frequency and type of contact with children and whether formal assessments of development are made at either routine or targeted visits. If a health visitor offered targeted contacts to some

children, then she[35] was asked how these children are identified. Four of the 10 questions gave participants the option of describing an 'other' category, increasing the flexibility of the questionnaire to reflect local variation.

These factual questions were followed by statements, designed to represent commonly held views about the CHPP and the process of reform, with which participants were required to either agree or disagree. The statements were devised by the researcher and tested for relevance and comprehensibility during the piloting process, A five point scale was used (strongly agree, agree, neither agree nor disagree, disagree, strongly disagree) for the series of questions. These questions were intended to explore the topic in a variety of ways, rather than relying on one question as an indicator (May 1997). Statements were written with the aim of being contentious and therefore provoking a strong response. Free text was invited at the end of the questionnaire where a space was provided for participants' own comments. This was intended to provide an insight into the concerns of practising health visitors which could be followed up in the qualitative study.

3.3.6 Data analysis

Analysis of survey data was carried out using the Statistical Package for the Social Sciences (SPSS, v12). SPSS is a suite of computer programmes which perform the functions of saving the data file, reading the data and carrying out the analysis, and producing a file of results (Foster 2001). It was developed to assist researchers in the analysis of social science data, uses a non-technically oriented syntax and is easy to learn for those with a limited computer and statistical background. It is now one of the most commonly used statistical software packages (Polit and Hungler 1995).

[35] Over 98% of health visitors are women (statistics taken from the NHS Hospital and Community Health Services Non-Medical Workforce Census (DH 2003b)).

Nominal data were analysed by looking at frequencies and associations between key variables. The chi square test was used for comparisons between groups of respondents, and significance determined using $p<0.05$. Because the data consist of randomly selected, independently measured cases, this meant chi- square could be used to give the probability of the relationship between variables and show how legitimate it is then to generalise to the whole population (May 1997). When analysing responses to statements, positive and negative scores were amalgamated to indicate overall agreement or disagreement.

For the purposes of analysis respondents were divided into three job groups; practising health visitors, health visitor managers and other practitioners. Those described as other practitioners were registered health visitors, providing preventive health care for pre-school children, but not routinely administering the CHPP. Such practitioners included specialist health visitors for specific groups (e.g. children with special needs, travellers and homeless families), Sure Start health visitors[36], named and designated child protection nurses, and practice nurses. In presenting the findings, the responses of the whole sample are given, unless there is a reason to present the individual data from each job group. Bivariate analysis, which shows the relationship between the independent variable and the dependent variable (May 1997) was used to explore the similarities and differences in the responses of these three groups.

Respondents were asked to indicate in what region or country of the UK they were working from a provided list. Data were analysed in relation to geographical region in order to establish whether there were differences in CHPP policy and practice in different parts of the UK. The NHS regions of

[36] 'Sure Start' is a government programme for children living in areas of high health inequalities (Hall and Elliman 2003). Some Sure Start programmes directly employ health visitors while others liaise with local health visitors employed by the NHS.

Northern England, Southern England, London, Midlands and Eastern England, Northern Ireland, Scotland and Wales were used for analysis.

Missing data were examined during initial cleaning and coding of data. Some respondent errors (for instance, misreading of routing following 'if yes'/ 'if no' questions) could be corrected, but where data were missing or uninterpretable, items were then recorded as missing (Swift 1996). As is normal practice 'missing values' cases have been omitted from the analysis, but their number was examined to permit assessment of their impact upon the conclusions of the analysis (Swift 1996). The chi-square test was used to determine significant difference in missing responses between job groups, and where there was a statistical significance this is reported in the findings.

Free text was an important resource derived from the survey. The advice of Boynton and Greenhalgh (2004), that the analysis of free text data in conjunction with a survey requires careful consideration for ethical as well as practical reasons, was taken into account. All free text comments were included in the analysis, rather than just the comments accompanying completed questionnaires. This gave a wider view of health visitors' views, as it meant that the comments from those not eligible to complete the questionnaire were included. Non-eligible registered health visitors included those working in other roles (from nursery teachers to university lecturers, and solicitors to social workers), retired health visitors, and those on maternity or sick leave.

3.3.7 Reflections on data analysis

The above account gives little indication of the many choices entailed in analysing the quantitative survey data. My research experience before carrying out this study was primary qualitative, so I came to the study with a theoretical rather than a practical experience of statistical analysis. My expectation was that the analytical process for quantitative data would be

more linear, clear cut and less iterative than qualitative analysis. In fact I was surprised to discover that I frequently revisited the raw data to clarify problems encountered in the course of analysis, and that at all points of the analysis I was making decisions about methods of analysis which had implications for the ultimate status of the findings. I will outline below the main choices which had to be made in data analysis.

3.3.7.1 Eligibility for inclusion

i) Defining which questionnaires to include in the study was more problematic than anticipated. The preliminary questions (see appendix 3.1, preliminary questions 1&2) were intended to select which participants were not eligible to take part. In practice many respondents stated they were not working with pre-school children, and then went on complete the questionnaire. In all cases where there was doubt about whether the respondent was eligible to complete the questionnaire I examined the questionnaire and made a decision on inclusion based on the respondent's current post as given in section 2 and any further information given. The most common discrepancy was when retired respondents stated they were no longer working but completed the questionnaire; here the questionnaire was included where the respondent stated they still did some part-time or bank work, but otherwise excluded.

ii) A further difficulty was when respondents were working with children but not as a health visitor. In these cases, questionnaires were included where the respondent was still working with pre-school children in a health setting (e.g. as a practice nurse giving CHPP immunisations) but excluded if the post had no specific health component (e.g. working in a nursery school). While the views of these respondents are in themselves interesting they could not be included in the survey as they fell outside the inclusion criteria.

3.3.7.2 Analysing responses to statements

A decision had to be made about how to analyse responses to the statement questions. It was apparent that some amalgamation of responses needed to be made as the five-part scale meant that there were too few in each category to demonstrate statistical significance. The choice was made to compare the amalgamated positive responses with combined neutral and negative responses, because for several questions up to a fifth of respondents put a neutral response. Therefore it was more useful to compare those who were in agreement with the others, in preference to comparing those who agreed with those who disagreed. This decision was discussed with a statistician who said that any comparison could be made as long as it was made clear what was being compared with what, and justification given for the choice. It is known that when offered a neutral category in attitude questions respondents are less likely to agree with a positive statement (Marsh 1979), which supports the choice of comparing positive responses with combined negative and neutral responses.

3.3.7.3 Analysing free text data

Free text comments were highly diverse, ranging from comments on the subject of the study to comments of the questionnaire design, as well as personal information about respondents. Further information about how these data were used is included in Chapter 4, section 4.8. Comments on the CHPP were sorted into analytical groups. Theoretically numbers of positive and negative responses could have been counted, but in reality this was not possible because there were so many shades of opinion which could not be clearly categorised. In addition, elements of favourable/unfavourable comments could co-exist in the same paragraph of free text. Such numerical analysis was not required in the study design, because the main reason for requesting free text comments was to gather ideas about the CHPP not included in the questionnaire, and which required further exploration.

3.4 Phase II: the interviews

From the start of the project there was an intention to conduct a two-part project, comprising a survey and then a more in-depth piece of qualitative research. Initially I had planned to carry out a two centre comparative case study. In this design, data would have been collected by a variety of mixed methods, to create a rounded holistic study (Hakim 1987) and the policy changes would have been investigated within a naturalistic setting. One centre or PCT would have been chosen in which the CHPP had been radically revised, while the other would have retained a more comprehensive universal programme. It would have been very attractive to include parents as service users in this study, but their inclusion would have required careful thought in order to identify in what ways they could have commented upon the relationship between policy and practice in child health promotion. Extensive piloting would have been required to determine whether this was possible and to refine the interview topic guide.

The case study methodology is well suited to situations where it is difficult to separate the phenomenon from its context (Yin 1993, 1994). Rather than looking at the CHPP reforms solely from the perspective of health visitors a wider variety of data collection methods would have been used, originating from a more varied group of stakeholders. This had the potential to provide an overall, contextualised view of current CHPP practice in two settings. Despite these potential benefits the 'survey plus case study' design was ultimately discarded in favour of the nested interview study with health visitors. The main reason for this was that the two phases worked together more effectively and productively as a mixed methods study. The interview study was best suited to keeping the focus on the relationship between policy and practice, and to understanding in more depth the issues raised by the survey findings. Together the survey and nested interview study provided a more cohesive and potentially informative overall research design.

The section on the interview study includes far more circumstantial detail about the research process than the account of the survey contains. This is because qualitative findings are highly dependent upon context and it is therefore important to make clear the relationship between the researcher and respondents, the setting, the recruitment process, and how the research was explained to the respondents (Hoddinott and Pill 1997).

3.4.1 Design

Interviews were carried out between October 2006 and January 2007. All 25 interviewees were registered health visitors, working in urban or inner-city areas of England. The sample was drawn from survey participants who had sent their details to the researcher in order to receive a summary of research findings. Those who solely wished to enter the £50 prize draw were excluded as it was felt that they had less interest in the project.

The decision was made to limit the sample to health visitors working with pre-school children in an urban area of high need because the child health promotion policy reform aimed to improve the lot of the most disadvantaged by targeting services to their localities and increasing the services provided by health visitors for this group. Therefore, in sampling the group most likely to have benefited from the policy change, it would be most revealing to discover whether services to those with the highest health and social needs had improved in practice. In this I was guided by free text comments from the survey which indicated that inner-city health visitors experience particular challenges in adhering to national policy guidelines.

Interviews were conducted by telephone to allow the participation of volunteers throughout the UK and to eliminate travel costs. Telephone interviews were conducive to an informal, conversational and speculative approach, which permitted exploration of the complex reasons why practitioners choose to practice in the way they do and the many subtle and

barely recognised influences that are brought into play. The relative anonymity of a telephone interview may have helped response when discussing areas where practitioners are potentially not conforming to agreed protocols, sensitivity and encouragement are needed to explore the reasons for this. In choosing telephone interviews it was recognised that such elements as observation of body language and non-verbal cues would be lost to the interviewer. However, all interviewees, by nature of their job, were people accustomed to talking on the telephone on a daily basis, often about sensitive subjects, so it was anticipated that interviewees would feel at ease in using the telephone and not feel constrained from expressing their opinion. Interviews were taped using a digital tape recorder, and then transcribed.

A topic guide (see appendix 3.5) was developed to explore health visitors' attitudes to child health promotion policy and practice, the extent to which local policy is based on local practice, and whether health visitors knowingly did not follow national CHPP policy in their practice. Because so little is known about how health visitors work preventively with parents, it was necessary to establish how interviewees administered the CHPP, before discussing the links between personal practice and public policy. Questions were devised using my background of experience as a health visitor, and findings of the survey. Free text comments from the survey were invaluable in defining the areas needing further exploration, including how staff shortages and cuts to services have affected take-up of policy within PCTs. Prompts were included to be used to stimulate responses if necessary.

The topic guide was piloted with a sample of three volunteers, who were all friends or colleagues of the researcher. Pilot study participants took part in a telephone interview, and were then asked for their views on the questions. As a result of this feedback, questions about what happened at each developmental review were reduced, and questions about policy altered to sound less interrogatory. It was apparent even at this stage that interviewees

did not like answering questions whereby they felt they were being tested on aspects of policy. As the topic guide was successful in eliciting responses which met the aims of the study, the three pilot interviews were included in the final sample. As well as confirming that the topic guide was capable of eliciting information and opinions about the changes to the CHPP, pilot interviews also brought out related topics which appeared significant to the interviewee but had not been anticipated by the researcher. These included the effect of the revised GP contract on the relationships within the primary health care team, and the impact of commissioning on the CHPP delivered.

3.4.2 Participants

In September 2006 all health visitors who had been recruited to the survey study and then had requested a summary of the research findings were contacted by letter or email. This explanatory letter invited health visitors working with children and families in urban and inner cities areas with high levels of health inequalities to take part in an interview study. Full details of the information given to participants are given in the explanatory letter/information sheet in appendix 3.6. If eligible health visitors wished to volunteer for a telephone interview they were asked to email the researcher. This may have limited participation in the study to those accustomed to using email, but as all health visitors were likely to have access to email at work, this was considered acceptable.

Numbers volunteering for the interview study were small in comparison with those who took part in the survey. After excluding those for whom there were no contact details and those who only wanted to take part in the prize draw (rather than having a summary of the findings), a total of 813 survey respondents were contacted by email or letter. Only one request for volunteers was sent out, which may have contributed to the low response

rate. Further requests were not made because of postage costs and because sufficient volunteers were obtained for the qualitative study.

TABLE 3.1. Number (percentage) of survey participants who volunteered to take part in the nested interview study

	Numbers of eligible survey respondents (n = 813)
Invitations to participate sent out	813
Volunteered for interview study	23 (3%)
Stated that did not wish to take part	18 (2%)
Did not respond	772 (95%)

It can be seen from Table 3.1 that 23 health visitors volunteered to take part in interviews. One volunteer was not eventually interviewed because it was not possible to find a convenient time to carry out the interview, leaving 22 volunteers who were subsequently interviewed. Three pilot study interviews were included in the total of 25 interviews. Some respondents gave reasons why they did not wish to take part, despite this not having been requested. The most common reason for respondents not to wish to take part was that they were no longer practising as a health visitor (10), in addition five were retired, and three stated that they did not work in an urban or inner-city area.

In contrast to the random survey sample, the interview study sought a self-identified volunteer sample. This reflects the different sampling requirements of quantitative and qualitative research. All 25 interviewees were from England, reflecting the smaller response from Scotland, Northern Ireland and Wales in the survey. There was over-representation from South West England, largely because pilot interviews were included in the sample. As well as being geographically unequally spread, interviewees were also atypical of the study population in having larger caseloads than the average

health visitor, and in being more highly qualified. Full demographic details of interviewees are given in chapter 5.

3.4.3 Ethical considerations

An application was also made to a multi-centre NHS ethics committee for a substantial amendment to be made to the favourable ethical opinion given for the survey in May 2005. A multi-centre committee was used because the research involved participants in more than one location. It was a condition of NHS ethical permission that interviewees would take place at home, in order to avoid having to negotiate ethical permission from each employing PCT to conduct an interview in work time. The committee also required confirmation that the Nursing and Midwifery Council (NMC) had no objection to the names of registered health visitors being used by the researcher to canvass for volunteers for the second part of the study. The NMC considered that the data base compiled by the researcher consisted of voluntarily given names and addresses, so had no objection. Ethical permission was also obtained from the Departmental Ethics Committee of the School for Policy Studies.

The information sheet (see appendix 3.6) gave information about the measures taken to preserve anonymity and these were reiterated verbally. Consent to be interviewed was asked of interviewees at the start of each interview; specific consent was asked to tape the interviews and to use direct quotations in writing up findings. All interviewees gave consent on all points. Some interviewees raised concerns about aspects of confidentiality during the interview. One interviewee had a very unusual clinical post-graduate qualification, which she knew that only a handful of health visitors had been awarded; it was agreed that this qualification would be referred to only in general terms. Two interviewees were concerned that they were expressing radical views and therefore wished to make sure of anonymity. One stated that she had consented to be interviewed because she was nearing the end of her career, and job security was no longer so important, but she would not

otherwise have expressed critical views in a political climate where health visitors were fearful of losing their jobs.

3.4.4 Validity

As a qualitative piece of research the interview study has a different claim to validity than the survey. The internal validity of a qualitative study rests on the relationship between the findings and the data collected- Do the findings reflect the views of the sample group? Is sufficient weight given to conflicting views in the analysis and the presentation of the findings? The accuracy of data collection, and the rigour with which the analysis is conducted and reported, are taken into account when considering the validity of the study. Although those who potentially read about the research do not have access to the raw data, transparent reporting of the process of analysis allows the reader to make their own assessment of the validity of the research.

> 'The strength of the qualitative study that aims to explore a problem or describe a setting, a process, as social group, or a pattern of interaction, will be its validity. An in-depth description showing the complexities of variables and interactions will be so embedded with the data derived from the setting that it cannot help but be valid. Within the parameters of that setting, population and theoretical framework, the research will be valid.' Marshall and Rossman (1989), p143

As with the survey the identity of the researcher has an influence upon the responses of participants, the way the research is carried out and the findings. Feminist research has been influential in highlighting the need for researchers to consider their subjective as well as objective role (Oakley 1981, Finch 1986). Richards and Emslie (2000) showed that the professional status of the researcher (whether a health professional or university researcher) had a consistent effect upon responses given in interviews. The majority of interviewees were aware that I was a health visitor as well as a researcher. Although there was some personal questioning in interviews, generally interviewees concentrated on describing their own experiences and giving their point of view, rather than being particularly inquisitive about my experience or views. For the most part it seemed that my identity as a health

visitor was most helpful in encouraging interviewees to talk freely, with the confidence that they would be understood. Therefore, while it is inevitable that my identity as a health visitor had an effect upon the findings, it cannot be said to limit their validity.

3.4.5 Data collection

The semi-structured interview methodology was successful in maintaining the focus of the interview on the areas within the topic guide, but also in allowing new ideas to be generated by the interviewee which had not been anticipated by the researcher. Such ideas could be explored and pursued, providing insights which added to my understanding of the area of investigation, and contributed to a deepening understanding of the area during the course of the 25 interviews. Concepts which arose in the early interviews (such as increased emphasis on practice conforming to policy - to the extent of supervisors being asked to check health visitors' diaries) could then be profitably added to prompts in later interviewees. Interviews gave an understanding of how the context in which change has come about has contributed to the content and structure of CHPP programmes.

Most interviews lasted over one hour, and interviewees almost universally appeared to see the interview as an important activity and were happy to give as much time as necessary. In one case an interviewee, who had forgotten that I was due to telephone, was in the middle of preparing the family evening meal, but preferred to take part in an interview rather than deferring it, and proceeded to give a 90 minute interview. A handful of interviewees were keen to limit the interview to a prescribed time, generally less than one hour, but in one case to half an hour. All but one interview was carried out at home in the evening; the remaining interview took place in work time at the request of the interviewee. Interviews were on several occasions interrupted by interviewees' children, who wanted their mother's

attention at bedtime. In a few cases this resulted in interview being cut short before all the questions were completed.

Interviewees did not like to display ignorance about policy, and frequently apologised for self-perceived lack of knowledge, citing colleagues who would have been able to give far more comprehensive answers. In responding to questions about policy, interviewees seemed anxious to provide the 'right' answer, which contrasted with great assurance in talking about their own practice. Where it became apparent that an interviewee knew about some aspect of policy that I did not know about, a few interviewees took great delight in pointing out my lack of knowledge and telling me that I 'should have known'. In this sense it seems that interviews were perceived by interviewees as taking place between peers, or if there was some imbalance of power, some interviewees took opportunities to make clear to me that I was not their superior. Several interviewees expressed satisfaction that they had taken part in the interview and felt it would contribute to raising the profile of the impact of recent CHPP policy changes.

In researching a subject which is primarily of concern to women (the health care of young children) by means of questioning members of my own almost exclusively female profession, the study has some links with feminist research. Nielsen (1990) has described how standpoint epistemology begins with the idea that less powerful members of society have a more complete view of social reality than others, precisely because of their disadvantaged position. In this case there was some element of exploring a hidden women's culture, which is often invisible to others outside the group. Cook and Fonow (1986) consider that the researcher who is a member of an oppressed class (women) as well as being a member of a more privileged class (scholars) potentially has a double consciousness which facilitates exploring women's perceptions of their experience from an experiential base. In the interviews health visitors made radical points which challenged the way that services for

children are managed and provided, making criticisms of how powerful influences such as the PCT and GPs make judgements based upon predominantly financial issues. Taking part in the interviews may have contributed to participants' awareness of how they and their clients are treated within and by services for children (Cook and Fonow 1986).

> 'Without conscious effort to reinterpret reality from one's own lived experience – that is, without political consciousness- the disadvantaged are likely to accept their society's dominant world view.' Nielsen (1990), p11

3.4.6 Data analysis

Some qualitative researchers insist on the terminology of qualitative data being 'generated' rather than simply collected and analysed (Mason 1994, Barbour 2008). As the researcher sifts and ponders on the raw data, always in the light of their own background experience and knowledge, a synthesis of the information begins to emerge from this creative process. Mason (1994) describes the process of developing an analysis as not being wholly distinct from the process of managing and sorting the data. As the researcher begins to devise coding systems and decides how to code different sections of data, it is inevitable that analytical and creative thinking is used. In practical terms the two activities of sifting data and producing an analysis are described as sequential and distinct, but in reality there is often an overlap (Mason 1994). This should be taken into account when reading the account given below of how the data was sorted and then the process of analysis begun.

Analysis of the qualitative material was undertaken using a thematic framework in order to classify and organise data according to key themes and concepts. Ritchie and Spencer's analysis framework (1994) was developed at the National Centre for Social Research and is widely used in qualitative analysis to facilitate rigorous and transparent data management

whilst allowing the analyst to move between levels of abstraction without losing sight of the raw data (Ritchie, Spencer and O'Connor 2003).

Ritchie and Spencer's analysis framework (1994) involves the researcher familiarising herself with the data, and then drawing out themes from each interview. This selected data is then reviewed against the whole data set in order to identify recurring themes and ideas. These initial categories were then used to code the data. Data was sorted to focus on each conceptual subject area in turn, then summarised and synthesised. From this an initial and provisional conceptual framework could be developed. Mason (1994) describes this traditional thematic approach, with strong links to grounded theory (Glaser and Strauss1967), as the most familiar technique used by qualitative researchers to get to grips with the data in a systematic way.

Although the technique of analysis described above has many parallels with grounded theory, caution is used in applying this term uncritically to the method of analysis. Denscombe (2007) has described how the term 'grounded theory' has come to be used rather loosely to refer to approaches that do not adopt the approach in its entirety and with rigour. He defines some of the key points of grounded theory as being that it adopts an emergent design and that the analysis is developed with constant reference to the fieldwork data as part of an iterative process. Plainly the analytical process I used has its roots in grounded theory, particularly in the use of 'the constant comparative method' as a means for analysing data. It differed from grounded theory in that I did not take a highly objective approach to the data, by which the data is seen as the source of meaning which is 'discovered by the researcher'. Whereas the earlier versions of grounded theory suggest that by means of the application of a highly systematic methodology the meaning will emerge inductively from the data, I have followed a more constructivist approach as described by Charmaz (2002).

> ‘The constructivist approach places priority on the phenomena of study and sees both data and analysis as created from the shared experience of researcher and participants and the researcher’s relationship with participants….. Constructivists view data analysis as a construction that not only locates the data in time, place, culture and context, but also reflects the researcher’s thinking.’
> Charmaz (2002) p 139

The process of analysis could have been managed using a CAQDAS (computer assisted qualitative data analysis) package, such as Atlas.ti or Nudist, which stores transcripts of the interviews and then allows text to be sorted under categories defined by the researcher. Bryman and Burgess (1994) point out that the construction of CAQDAS computer programmes has been influenced by grounded theory and CAQDAS lends itself to this approach. The process used by the computer differs very little from how this stage of analysis would be completed by hand, as the researcher must define the categories and apply them to the text. For this study I close to conduct the analysis by hand rather that using CAQDAS. I had previously used CAQDAS (Atlas.ti) in a much larger study, where the amount of data (over 100 interviews) meant that the use of computer analysis was needed to make the process more manageable for a team of researchers all engaged in coding and analysis. Because in this case the amount of data was relatively small, I chose not to use CAQDAS in order to gain experience of using a more basic approach. In practice I found that there were very few differences in ease of using the system or outcome between the two methods of analysis. Reading paper versions of the transcripts was a more familiar process than reading transcripts on the computer screen, and possibly allowed greater intimacy and familiarity with the data.

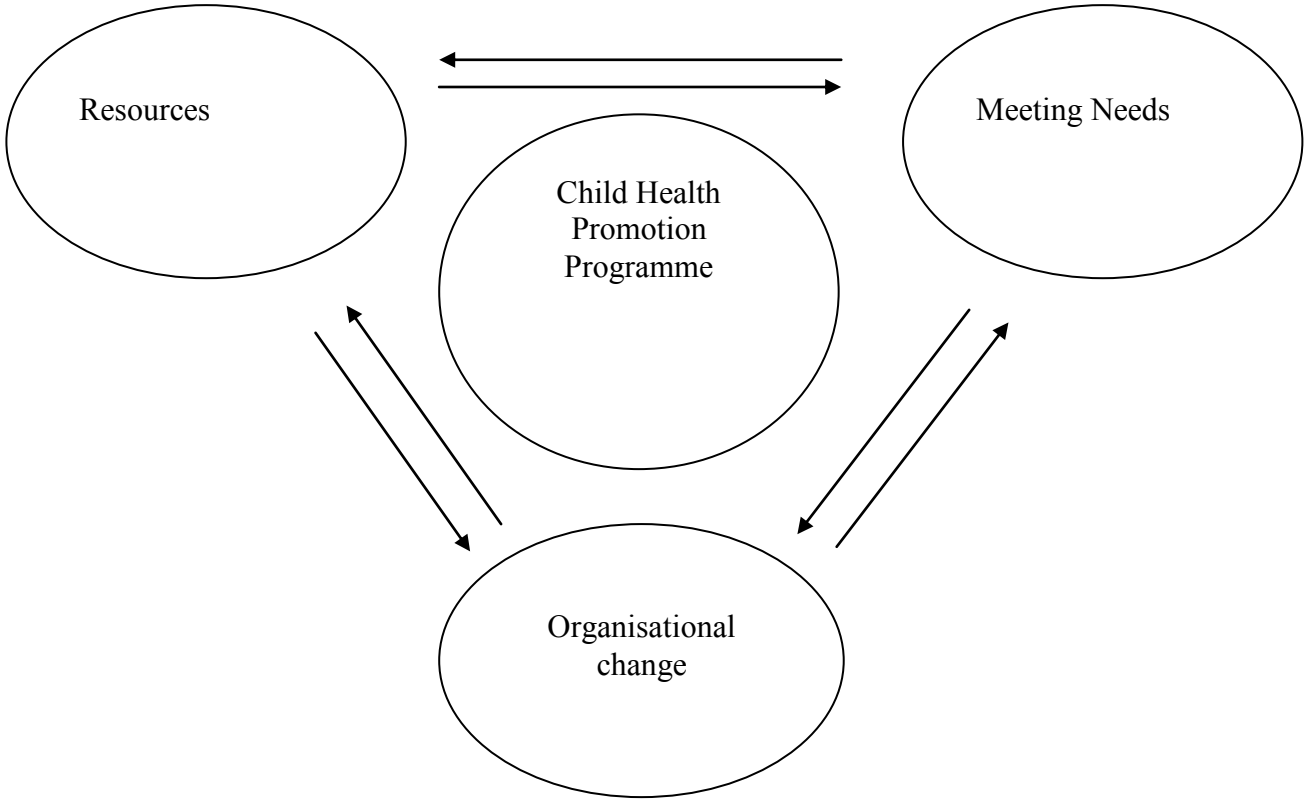
3.4.6.1 Identifying themes

The initial themes emerging from the data were very pragmatic, and related to health visitors and ways of working, the CHPP and how it had been administered, clients and policy. Although these headings covered the content of the interviews and identified some important ideas, they were

diverse and failed to keep the focus on the CHPP. While it was important to explore the context of the changes and to follow health visitors' perspectives on the meaning of these changes for them, it was also important to keep the focus of the research and not allow it to be lost under a mountain of other ideas raised by interviewees. Therefore I returned to the transcripts and conducted an exercise of sorting pieces of text under more focused headings, which examined how the CHPP was centred within the accounts of health visitors. During this process the central ideas of a conceptual framework began to arise from the data.

The emerging ideas fell under three headings; meeting clients' health needs, organisational change and resources - all of which were related to the overarching theme of the CHPP. Each of these four main themes could be seen as relating to the others, providing a conceptual framework which facilitated the development of theory in tandem with the incorporation of pre-existing knowledge, and which led to the assessment of implications for policy and practice from the data. This framework was more satisfying than the initial more pragmatic coding because it allowed a model to be devised of how health visitors reacted to change to the CHPP and worked within the change, without losing the wider context of influences on children and families, the wider communities and other welfare and health agencies. The model also worked well because it could be used to portray the experiences of health visitors who found the changes to the CHPP helpful, as well as health visitors who were struggling to work under the new regime.

FIGURE 4.2 Conceptual framework drawn from themes arising from interview data



In this diagram the arrows show how each of the main three areas relating to the child health promotion programme feed into each other. Thus, the way the CHPP operates is related to the pre-existing needs and to the extent to which these are met, which is in turn dependent on the resources available, and all is dependent upon the process of organisational change and the environment this has created for carrying out the CHPP. It can be seen that if all these areas function efficiently, a virtuous circle is formed in which the process of change results in a CHPP which meets the needs of clients and which is supported by adequate resources. Conversely if any aspect of the circle is deficient (e.g. the organisation is in turmoil or the enforced CHPP is perceived as poor by practitioners) this will affect all other aspects of the circle.

3.5 Conclusion

This chapter has described the methodology of the empirical research project, and given the reasons why the research was planned and carried out in this way. The next three chapters are concerned with the study findings; Chapter 4 presents the findings from the survey, and Chapters 5 and 6 the interview findings. The conceptual framework given above in diagrammatic form (figure 4.2), is used to structure the presentation of the qualitative findings in Chapters 5 and 6.

Chapter 4

Survey findings

In this chapter I shall present and discuss the findings of the survey component of the study (phase 1). These findings were published in an article in the Journal of Advanced Nursing in June 2008 (see appendix 4.1).

4.1 Who were the respondents?

Respondents came from all regions of the UK: England (90%, 929), Wales (5%, 52), Northern Ireland (3%, 28) and Scotland (1%, 7). A small number of respondents did not give their region, or were based outside the UK (e.g. working within the armed forces). These made up 1% (13) of the total. Percentages and numbers from the English regions were as follows;

- South East (21%, 221)
- North West (13%, 140)
- Northern and Yorkshire (12%, 122)
- South West (11%, 117)
- London (10%, 104)
- West Midlands (9%, 90)
- Trent (7%, 70)
- Eastern (6%, 65)

The reasons for the disparity in response rates between regions are not known. A possible explanation for the larger response from the South Eastern area is that at the time of the survey there was publicity about health visitor jobs being under threat in some parts of the South East, which may have motivated respondents to take part in a study about their work. The smaller response from Wales, Northern Ireland and Scotland is likely to be due to the questionnaire being less well adapted to practitioners outside England. For instance, although being included within health visiting by the NMC, Scottish health visitors are more commonly known as public health

nurses Health visitors in Wales are employed by health authorities rather than PCTs, so the reference to PCTs may have been alienating to this group.

When the job group of respondents was analysed it was found that most respondents were practising health visitors (86%, 901). Those who described themselves as both generic health visitors and health visitors for children and families were in included in this group. The remaining respondents were divided between other early years practitioners (9%, 93) and health visitor managers (5%, 49).

'Other early years practitioners' were health visitors working with pre-school children in a variety of settings, who did not necessarily directly administer the CHPP as part of their current role. In this chapter they are described as 'other practitioners' throughout. This group included nurse practitioners and practice nurses, and health visitors for specialist areas (such as child protection, special needs (adult and child), Sure Start and paediatric liaison), and for special groups (e.g. homeless families, refugees, asylum seekers and travellers). Some, such as practice nurses or nurse practitioners, were directly involved in providing the CHPP, for instance by giving immunisations, but did not see children routinely for preventive health care. Many specialist health visitors, such as child protection lead nurses, rarely carried out any direct CHPP work, but were aware of the programme reform and able to comment on its impact upon health visitors' work.

Those from the 'other practitioner' group were less likely to answer questions than respondents who were managers or standard health visitors; therefore findings from this group should be viewed with more caution. It was understandable that if this group were not carrying out routine CHPP contacts that they would not answer questions on this subject. By contrast, questions where respondents were asked to give their opinion about CHPP changes, were relatively well answered by 'other practitioners'. Free text

comments were proportionally higher from this group than from the other two groups. Many prefaced free text comments saying that they had been unable to complete the questionnaire because their job included little or no routine child health promotion.

4.2 Presentation of findings

Findings are presented thematically. The five main subject areas are:

- local policy on the CHPP
- implementation of local CHPP policy
- how health visitors administer the CHPP
- assessment of need
- background and supporting opinions

Tables are used to present the overall findings and to show comparisons between the responses from different job groups. On many key points there was a statistically significant difference between the responses of the three different groups. None of the subsequent tables make comparison between regions because no statistically significant differences were found between regions on any of the variables. This suggests that there were no distinct regional variations in CHPP practice across the UK.

Missing responses are not included in tables[37], but the number of missing responses is apparent from the total number of responses to the question as compared with the number in each group. These figures are given for each table. On variables where only health visitors might be expected to be able to respond (for instance carrying out the CHPP), statistics are limited to the main practising health visitor group (tables 4.4 and 4.8). On questions where there were a significant number of missing responses from the 'other practitioner' group, analysis of statistical significance was limited to the

[37] Missing responses are given in full in the journal article included in appendix 4.1.

remaining two groups. The two instances in which this was done are noted within the text and tables marked with an asterisk.

An analysis of the free text data is given after the presentation of the main body of the survey findings.

4. 3 Local policy on CHPP

Virtually all respondents (98%, 1002) confirmed that the primary care provider organisation (or Primary Care Trust) for which they worked had a CHPP. Most of these programmes had been revised since 2004 (33% in 2004 and 31% in 2005), with only 2% (18) stating that it had not been revised. In total 85% of respondents (897) said that their local CHPP had been subject to revision. This shows how widespread the change in CHPP practice has been across the country. It should be remembered that there was no significant difference between regions on any point, demonstrating that change has been geographically consistent.

It was important to discover in what way CHPPs had changed. Respondents from areas where the local CHPP had been revised (n = 897) were asked to state whether the recommended frequency of routine and targeted HV contacts with pre-school children had increased, decreased or remained unchanged since the policy revision. An increase in targeted health visitor contacts is a tenet of both the fourth Hall report (targeted face to face health visitor contacts from 4 months of age (Hall and Elliman 2003)) and the NSF for Children (targeted contacts from the health visitor from one year of age onwards (DH 2004a)).

It can be seen from Table 4.1 that where the CHPP had been revised three-quarters of all respondents agreed that this generally resulted in fewer routine contacts at prescribed ages, a picture which is in line with national policy direction. This suggests that with regard to reducing routine contacts

with children local policy changes have followed national policy directives. There was no statistically significant difference between the responses of different job groups (health visitors, managers and 'other practitioners') on the reduction in routine visiting.

TABLE 4.1 Percentage (number) of respondents, whose local child health promotion programme (CHPP) had been revised (n = 897), reporting changes to the number of routine contacts recommended in local policy.

Changes to the CHPP since revision of the local programme	Routine contacts increased	No change	Routine contacts decreased	Total
Health visitors (n = 770)	6% (45)	18% (126)	76% (531)	(702)
Other practitioners (n = 80)	6% (3)	16% (9)	78% (43)	(55)
Managers (n = 47)	12% (5)	19% (8)	69% (29)	(42)
All respondents (n = 897)	7% (53)	18% (143)	75% (603)	(799)*

* There was a statistically significant difference in missing responses between the three groups ($p<0.0005$), but no statistically significant difference in missing responses between managers and health visitors ($p = 0.412$). Therefore statistical analysis of findings was confined to managers and health visitors.

This decrease in routine contacts was not matched by a parallel increase in targeted visiting (see Table 4.2). Thus it appears that although local CHPPs have been revised to reduce routine contacts, in line with national policy, in the majority of instances this has not been matched by an increase in targeted interventions. When comparison was made between the responses of health visitors and managers, it was found that managers were more likely than health visitors to consider that targeted visiting had increased, rather than staying unchanged or having decreased ($p=0.003$). Over half of

managers thought that targeted contacts had increased since CHPP policy revision, but most health visitors stated that targeted contacts had remained at the same level. Thus health visitors presented a picture of a service in which routine contacts were reduced, but the accompanying redirection of the service towards those with highest needs had not consistently happened.

TABLE 4.2 Percentage (number) of respondents, whose local child health promotion programme (CHPP) had been revised (n = 897), reporting changes to the number of targeted contacts recommended in local policy.

Changes to the CHPP since revision of the local programme	Targeted contacts increased	No change	Targeted contacts decreased	Total
Health visitors (n = 770)	37% (246)	50% (329)	13% (84)	100% (659)
Other practitioners (n = 80)	44% (25)	37% (21)	19% (11)	100% (57)
Managers (n = 47)	59% (24)	41% (17)	0% (0)	100% (41)
All respondents (n = 897)	39% (295)	48% (367)	13% (95)	100% (757)*

* There was a statistically significant difference in missing responses between the three groups (p = 0.003), but no statistically significant difference in missing responses between managers and health visitors (p = 0.479). Therefore statistical analysis of findings was confined to managers and health visitors.

4.4 Implementation of local policy

Respondents were questioned on the process of implementation of local policy by means of a series of statements with which they were asked to express agreement, disagreement or neutrality. These statements related to whether either health visitors or parents had been involved in the process of CHPP reform (see Table 4.3).

There was a highly significant statistical difference between the responses of health visitors, managers and 'other practitioners' to all these statements. While more than three-quarters of managers said they had the opportunity to be involved in the process of change, less than half of health visitors considered they had been involved. Similarly, health visitors and 'other practitioners' were much more likely to consider that changes to the programme had been imposed on health visitors, than were managers. This suggests that the majority of health visitors felt excluded from the process of reforming the CHPP programme, but that managers believed that health visitors had been given the opportunity to take part in the process.

TABLE 4.3 Percentage (number) of respondents who agree with statements regarding implementation of policy (CHPP)

(Chi square test results are shown for the comparison of agree with disagree/neutral responses)

	Health visitors agree (n = 901)	**Other practitioners agree** (n = 93)	**Managers agree** (n = 49)	**All respondents agree** (n = 1043)	**p value**
Implementation of policy					
I am given the opportunity to be involved in decisions about the CHPP	47% (414)	57% (44)	79% (38)	49% (496)	p<0.0005
Changes to the CHPP have been imposed upon HVs	60% (531)	38% (31)	29% (14)	57% (576)	p<0.0005
Parents have the opportunity to be involved in decisions about the CHPP	9% (81)	18% (14)	21% (10)	10% (105)	p=0.002*

* One cell had below the minimum expected cell count using chi-square test.

While there were differences of opinion between practitioners and managers in the extent to which health visitors had been consulted about the process of change, there was more unanimity about the involvement of parents. Overall, less than a quarter of any group considered that parents had been given this

opportunity. Again there were differences of opinion between job groups. While less than 10% of health visitors considered parents had been involved in decisions about the CHPP, managers and 'other practitioners' more significantly more likely to agree with this statement. This could reflect greater knowledge of the consultation process among managers and 'other practitioners' or a greater readiness to give an opinion which reflects more favourably on the process of CHPP reform.

4.5 How health visitors administer the CHPP

In total 95% of all respondents (961) stated that routine contact was made with children at prescribed ages according to the local CHPP. To ascertain whether practice followed national guidance on CHPP, routine contacts were analysed according to the child's age at the contact and the means of contacting the family. Table 4.4 shows the ages at which routine contacts were offered and the nature of the contact. This table is based on the responses of practising health visitors only (n = 901), as managers and 'other practitioners' would be unlikely to be involved in day-to-day administration of the CHPP.

TABLE 4.4 Percentage (number) of health visitor respondents making routine face to face, letter or telephone contacts with pre-school children and families (n = 901).

ROUTINE CONTACT	Face to face	Letter only	Telephone only	No contact	Total
Before 8 weeks	96% (834)	1% (6)	2% (16)	1% (11)	100% (867)
At 6 months	29% (256)	2% (14)	3% (23)	66% (577)	100% (870)
At 9 months	72% (632)	5% (42)	1% (10)	22% (190)	100% (874)
At 1 year	20% (178)	7% (59)	3% (28)	70% (612)	100% (877)
At 2 years	56% (496)	25% (217)	2% (17)	17% (148)	100% (878)
At 3 ½ years	23% (203)	33% (289)	3% (27)	41% (359)	100% (878)

From Table 4.4, it can be seen that 96% of responding health visitors (834) routinely make a face-to-face contact with children in the first 8 weeks of life. As the child becomes older, the number of face-to face contacts decreases, but peaks at traditional times for routine contacts, such as nine months and two years (contact times recommended in previous Hall reports (e.g. Hall 1996)). Over three-quarters of health visitor respondents (699) stated that routine face to face contacts would cease between two years and school entry. This suggests a discrepancy between local practice and national recommendations as the NSF for Children (DH 2004a) states that a face-to-

face contact with a health visitor is not necessarily required after the one year assessment.[38]

The discrepancy between national policy and local practice is partially illuminated by responses to Likert statements about the age at which targeting begins (see Table 4.5). Hall and Elliman (2003) recommend that following assessment at 4 months of age, babies and children should be seen face to face by a health visitor on a targeted basis only[39]. However, only 21% of all respondents (210) agreed that health visitors should see children to four months and then only where there is an identified need. On this question, there was no statistically significant difference between the responses of health visitors, managers or 'other practitioners', suggesting an entrenched resistance among health visitors to replacing routine contacts with a model of targeting after assessment at 4 months.

The confusion between the recommendations of the fourth Hall report (targeting after 4 months) and the NSF for Children (targeting after one year) is exemplified by the spilt in opinion about when targeting should begin. The recommendation of the NSF for Children for targeting after one year of age may be assumed to have superseded that of the fourth Hall report (2003). However, 20% of health visitors and 28% of managers still believe in targeting health visitors' contacts after 4 months of age.

Turning to targeting at one year of age, only 38% of all respondents agreed that health visitors should only see children with an identified need after this

[38] 'By the first birthday: [after] systematic assessment…the health visiting team will …agree future contact with the service. [At] two-three years: the health visitor will exercise professional judgement and agree with the parents how this review is carried out. It could be done through early years providers or the general practice, or by offering a contact in the clinic, home, by post, telephone or email. Use is made of other contacts with the primary care team (e.g. immunisations, visits to the GP etc)' (DH 2004a, p25-26).

[39] 'We recommend that after the third dose of vaccine at 4 months, the HV should negotiate the nature of subsequent reviews. It is up to the parents and professionals together to decide on what should be done, in the light of individual needs and, inevitably, of competing priorities…where a family is well know to the PHCT a formal contact may not be necessary (Hall and Elliman, p355)'

age. There was a statistically significant difference between the responses of health visitors, managers and 'other practitioners' on this point. Managers, in line with the National Service Framework for Children (DH 2004a), were more likely to agree that targeting face-to-face health visitor contacts after one year of age was preferable (56% of managers agreed with targeting after year, compared with 38% of health visitors) . What is not known from this survey is how managers' views about targeting affected the practice of health visitors. It is clear, however, that managers and health visitors have very different views about the desirable mix between routine and targeted contacts with pre-school children.

TABLE 4.5 Percentage (number) of respondents who agree with statements on targeting

(Chi square test results are shown for the comparison of agree with disagree/neutral responses)

	Health visitors agree (n = 901)	**Other practitioners agree** (n = 93)	**Managers agree** (n = 49)	**All respondents agree** (n = 1043)	**p value**
Targeting					
Health visitors should see children routinely to 4 months and then only where there is an identified need	20% (178)	24% (19)	28% (13)	21% (210)	p=0.358 (NS)
After 1 year health visitors should see children only where there is an identified need	38% (334)	37% (30)	56% (27)	38% (391)	p= 0.033
Playgroup/nursery workers can identify problems requiring referral	53% (471)	69% (59)	67% (32)	55% (562)	p= 0.004
Parents know how to seek help for children's problems	35% (309)	34% (26)	40% (19)	35% (354)	p= 0.784 (NS)

The responses shown in Table 4.5 give some indication of why health visitors may continue to make routine contact with children after the first year, contrary to the recommendations of national policy. When considering whether playgroups or nursery workers can identify problems requiring referral there was a statistically significant difference between the responses of different job groups. Over two-thirds of 'other practitioners' and managers considered such workers could identify problems requiring referral, while only just over half of health visitors agreed they could do so. This suggests that either health visitors are trying to hang on to their role of being the professional who assess children and make referrals, or that they find in practice that child care workers cannot do this. In this instance it is interesting that the views of 'other practitioners' accord with managers rather than health visitors, as many 'other practitioners', such as those for children with special needs, are more likely then general health visitors to have contacts with child care workers. However, given the heterogeneity of the make-up of this group it is important not to place too much significance on this finding.

While over half of all respondents thought that child care workers could identify children requiring referral, only just over a third of respondents thought that parents knew how to seek help for their children's problems. Less than half of any job group agreed that parents know how to seek help for children's problems, with no significant difference between responses. Given that the whole revised CHPP is based upon the supposition that parents are the best people to identify children's needs, it is highly worrying that all job groups have doubts about whether parents are able to do this. This finding strongly suggests that more evidence is needed about whether parents are able to identify problems and seek help appropriately.

4. 6 Assessment

Assessment is particularly important in the new model of child health promotion because it is the means by which it is decided which children and families receive a targeted health visiting service. If not identified as having needs warranting targeting, babies could be left after either 4 months or 1 year, with no routine face-to-face health visitor contact. Instead review at further key stages (one year, two to three years) may be satisfied by having recently seen a GP, or attended for immunisations. It is not known what child health promotion activities are carried out at such contacts by GPs, practice nurses or nurse practitioners. Assessment of need could therefore be seen as either opening or closing the gateway to further health promotion contacts with a health visitor.

4.6.1 Assessing needs

Table 4.5 shows the methods of assessing need in order to target health visiting services at those with identified health needs. All respondents strongly agreed that the health visitors' professional judgement was the most important factor in identifying need for targeted services. Managers were equally certain that professional judgement was the deciding factor in assessment as practitioners; they rated it as almost twice as commonly used than local protocols, and over twice as likely to be used as a needs assessment tool. This demonstrates the primary role of health visitors' professional judgement in deciding which children need targeted services, in the eyes of both managers and practitioners.

TABLE 4.6 Percentage (number) of respondents using methods of needs assessment to identify children in need of targeted health visiting services.

	Health visitors (n = 901)	**Other practitioners** (n = 93)	**Managers** (n = 49)	**All respondents** (n = 1043)	**P value**
HV professional judgement	97% (850)	92% (55)	98% (47)	96% (952)	P=0.121 (NS)
Other professional's judgment	52% (460)	59% (35)	69% (33)	54% (528)	p=0.056 (NS)
Corporate team assessment of need	31% (272)	41% (24)	46% (22)	32% (318)	p=0.036
Needs assessment tool	36% (318)	46% (27)	38% (18)	37% (363)	p= 0.334 (NS)
Local protocol	41% (358)	39% (23)	48% (23)	41% (404)	p= 0.587 (NS)
Framework for assessment of children in need	87% (769)	78% (46)	88% (42)	87% (857)	p= 0.116 (NS)

Managers and 'other practitioners' were statistically significantly more likely than health visitors to state that a corporate team assessment of need was made prior to targeting. This indicates that they perceive assessment far more as a team activity, whereas in practice it is health visitors who are predominately making assessments about which children to target. From the survey it is not apparent if health visitors who took account of the judgement of team members when making an assessment were more likely to work in multidisciplinary or corporate teams. Alternatively respondents who made a corporate team assessment may have been thinking of the wider PHCT, including GPs and practice nurses. It is certainly the opinion of both Hall and Elliman (2003) and the NSF for Children (DH 2004a) that such PHCT members play a large part in delivering the CHPP, although generally after a needs assessment carried out by a health visitor.

Turning to the tools used to assess need, by far the most common method of assessment was the 'Framework for the Assessment of Children in Need' (DH 2000a). This is a model of assessing whether children are in need or in need of protection, which was primarily developed for use by social workers. Very high percentages of both health visitors and managers described this tool as being used as a method of assessing need. It is interesting that this tool was being used to decide whether children required further contact with a health visitor for health promotion activities, when this was not the purpose for which it was devised. This indicates that when assessing need for health visitor contacts the child protection model dominates. Under this model children perceived at risk of abuse are targeted for future contact. While this is understandable, it could be argued that a much lower threshold is needed for deciding which children are in need of a preventive health service. It should be remembered that, under the CHPP given in the NSF for Children (DH 2004a), a child judged as not needing targeting at one year may receive no further face-to-face child promotion contacts until school entry.

Less than half of any group considered that a needs assessment tool or local protocol was used to give guidance about which children to target for further health visitor-led health promotion contacts. This suggests that little thought has been given to the best way of identifying children who would benefit from anything but the minimal health promotion service offered routinely to all children. It seems that a high threshold has been taken for identifying a need for targeted services. The NSF for Children (DH 2004a) places responsibility on the health visitor for making a 'systematic assessment of need' by the first birthday but does not clearly state how this should be done. This has led to a lack of clarity in practice about the way in which children are assessed as being in need of targeted health promotion contacts.

4.6.2 Developmental assessment

The majority of all respondents stated that a developmental assessment tool was used in practice (85%, 867). When broken down into job group this was health visitors 86% (765), managers 80% (39) and 'other practitioners' 77% (63). There was no statistically significant difference between the job groups, suggesting that all groups consider them to be in common use.

Given the significant lack of any mention of developmental assessment carried out by the health visitor in the NSF for Children (2004a), this presents an interesting picture of consensus in practice which is not led by policy. Hall and Elliman (2003) maintain their stance that formal screening tests should not be used as part of a child health promotion programme. They claim that emphasis has shifted from developmental screening to primary prevention and opportunistic intervention because disorders are noticed primarily by non-health professionals (parents, friends and child care staff), there is a lack of evidence for any benefits of formal developmental screening and there is lack of agreement about what constitutes normality. In practice health visitors, with the support of their managers, have continued to carry out developmental assessments, using tools designed to give an objective view of individual developmental progress.

Further details about which tools were used to assess development was more difficult to glean from the survey. A list of developmental tools was offered to respondents. Sheridan (Sheridan 1973), Denver (Frankenberg *et al* 1992), Warwick (Spencer and Coe 2001) and the Schedule of Growing Skills (Bellman, Lingan and Aukett 1996) are more general development assessment tools, while the Checklist for Autism in Toddlers (National Autistic Society 2005) is used specifically to identify autism. The results are presented in Table 4.8, which shows which tools are used, and whether

routinely or targeted[40]. This table is derived only from the responses of health visitors as it can be assumed that in practice few managers or 'other practitioners' were carrying out routine assessments.

TABLE 4.7 Percentage (number) of health visitors (n = 901) who use a developmental assessment tool universally or targeted

Developmental assessment tools	Used by health visitors	Routine or Targeted	
Denver	12% (106)	Routine Targeted	5% (44) 6% (51)
Schedule of Growing Skills (SOGS)	31% (281)	Routine Targeted	8% (68) 18% (162)
Sheridan	49% (436)	Routine Targeted	21% (189) 11% (99)
Checklist for Autism in Toddlers (CHAT)	25% (222)	Routine Targeted	4% (35) 16% (143)
Warwick	1% (4)	Routine Targeted	<1% (2) <1% (1)
Locally devised tool	28% (249)	Routine Targeted	13% (119) 3% (28)
Other developmental tool	5% (42)	Routine Targeted	1% (13) <1% (8)

Numbers of practitioners using each tool were small. The most commonly used tool among all respondents was Sheridan, which almost half of health visitor and manager respondents described as being used to assess development. The Sheridan developmental charts sets clear parameters for 'what children should do at each age' (Sheridan 1973). From the survey

[40] Not all the respondents who stated that they used the tool then answered the question whether they used it routinely or targeted; therefore numbers do not agree.

questions it is not clear whether health visitors were using the tool as an actual screening device, or whether they meant this was how their thinking about a child's development was formed. It could be that 'Sheridan' is the framework that health visitors have in their heads and therefore is the tool they use to assess development. While Sheridan was used most often for routine developmental assessment, the Schedule of Growing Skills (SOGS) is commonly used as a targeted assessment, with almost a fifth of health visitors using it in this way.

It appears that developmental assessment is used by a significant number of health visitors as part of the CHPP programme. It is not solely used as a targeted assessment but is also used routinely to assess children's development. This suggests that health visitors ascribe an importance to developmental assessment which is not matched in policy. It is highly noteworthy that a locally devised tool was second to Sheridan in routine assessment. The fact that an assessment tool has been devised locally suggests that developmental assessment continues to be part of routine health promotion for children in local policy, despite its absence in national policy.

4.7 Background opinions

In this section an attempt is made to examine the background or supporting opinions which lead health visitors to make the choices they do about their CHPP practice. This is done by looking at respondents' opinions on the significance of routine visiting and the place of evidence base in justifying health visiting practice.

4.7.1 The importance of routine visiting

Tale 4.9 shows the opinions of the different job groups on the significance of routine visiting. Over three quarters of all respondents thought that without routine visiting children's problems could be missed. When viewed in

conjunction with previous findings, such as child care workers and parents not being considered reliable in identifying health problems, this suggests that health visitors perceive themselves as having a central role in recognising health needs and ensuring they are dealt with. High numbers of respondents (71%) considered that without regular visiting they could not get to know families. It appears that there is some link between familiarity with families and being able to identify health needs effectively.

There are many significant differences in opinion between the three job groups in relation to the importance of routine contacts. Whereas almost three-quarters of health visitors considered that it was hard to get to know families without routine visiting, only just over half of managers agreed with this. Over three-quarters of all respondents from all groups thought that problems can be missed if children are not seen routinely, but there was a significant difference between the numbers of health visitors agreeing with this statement (81%), and the numbers of managers (67%).

There was also a highly significant difference in numbers agreeing with the statement about whether reduced routine contacts had 'freed up' health visitors to do more public health work. While two-thirds of managers considered that this was so, only just over a third of health visitors agreed that they had been able to do more public health work. This is a startling difference in perception between practitioners and managers, suggesting that managers are either out of touch with the work of their staff, or that they have a positive view of policy which leads them to interpret what is happening in practice differently from practitioners.

Interestingly there was no significant difference between the responses of the three groups to the statement 'I have continued to make routine visits to all children because of the needs of the area in which I work'. Just over a third of health visitors and 'other practitioners' agreed with this statement, while

only 21% of managers did so. Although not statistically significant, this difference in opinion suggests that this question requires further investigation. Where children in an area have high needs, the boundaries between routine and targeted contacts appeared to be problematic to define.

TABLE 4.8 Percentage (number) of respondents who agreed with statements about routine visiting (CHPP)

(Chi square test results are shown for the comparison of agree with disagree/neutral responses)

	Health visitors agree (n = 901)	**Other practitioners agree** (n = 93)	**Managers agree** (n = 49)	**All respondents agree** (n = 1043)	**p value**
Routine visiting					
Problems can be missed when children are not seen routinely	81% (717)	70% (57)	67% (32)	79% (806)	p=0.007
Without routine visiting I find it hard to get to know families	73% (647)	61% (46)	51% (24)	71% (717)	p=0.001
I have continued to make routine visits to all children because of the needs of the area in which I work	35% (308)	36% (22)	21% (10)	34% (340)	3.7 (2) p= 0.157 (NS)
I feel confident in identifying which children to target	75% (664)	71% (55)	92% (43)	75% (762)	p= 0.024
Targeted visiting can make clients feel stigmatised	45% (397)	35% (29)	38% (18)	43% (444)	p=0.142 (NS)
Targeted visiting is preferable to routine visiting	46% (399)	44% (35)	65% (31)	46% (465)	p= 0.033

Turning to the statements about targeting, it is highly interesting to note that overall three-quarters of respondents felt confident about identifying which children to target. This can be perceived as a ringing endorsement of the revised CHPP which is based on the ability of health visitors to use their professional judgement in order to make an assessment of need and then deliver services at the appropriate level. However, this does not hold true with the opinions expressed above about the importance of routine visiting. There was a significant difference between the responses of job groups. While 92% of managers considered health visitors were confident to target, practising health visitors were least certain of this, with 75% agreeing that they felt confident. This suggests that managers have more faith in the assessment process than health visitors, although generally all agree that health visitors can target. It may be that a certain amount of routine visiting has to be done before targeting can be reliably carried out.

Less than half of non-managers considered targeting preferable to routine visiting. Predictably there was a significant difference between the responses of managers and others on this variable, with over two-thirds of managers considering targeted visiting as preferable. However, less than half of all respondents considered that targeting would lead to clients being stigmatised. Although more health visitors felt that clients might be stigmatised than managers or 'other practitioners' there was no statistical difference between responses. It is unknown to what extent lack of stigmatisation for targeted clients was reliant upon the existence of a universal service and a certain level of routine visiting. Over a third of all job groups considered that targeting could make clients feel stigmatised.

Responses in this section suggest that although targeting is something that health visitors are confident to do, they still feel that routine contacts are important. Assessment is not necessarily seen as a one-off process which can be done and then children forgotten once they are neatly categorised.

Instead health visitors seem to believe that routine visiting is needed because problems may develop, and the health visitor is best placed to identify these needs. It is also shown that the opinions of managers and practitioners are at variance on the importance of routine visiting and the desirability of targeting.

4.7.2 The evidence-base for health visiting

The responses to statements about the evidence base for various aspects of health visiting were helpful in setting CHPP within the context of health visiting work and revealing how different job groups perceived the value of different aspects of this work. As such they were invaluable in providing insights which could be followed up in the subsequent qualitative study.

TABLE 4.9 Percentage (number) of respondents who agreed with statements regarding the evidence-base for health visiting.

(Chi square test results are shown for the comparison of agree with disagree/neutral responses)

Statements	**Health visitors agree** (n = 901)	**Other practitioners agree** (n = 93)	**Managers agree** (n = 49)	**All respondents agree** (n = 1043)	**p value**
It is important that all health visiting interventions are evidence-based	80% (709)	76% (63)	85% (41)	80% (813)	0.421 (NS)
Routine health visitor contacts with children are evidence-based	42% (369)	41% (33)	40% (19)	42% (421)	0.951 (NS)
Targeted health visitor contacts with children are evidence-based	58% (512)	51% (42)	67% (32)	58% (586)	0.224 (NS)
Health visitor public health work is evidence-based	64% (573)	70% (57)	53% (25)	63% (655)	0.148 (NS)
Universal developmental screening is evidence-based	51% (448)	54% (42)	36% (16)	50% (506)	0.117 (NS)

All respondents agreed that the evidence-base was important (80%), with managers leading the way (85%). Less than half of any group thought that routine contacts with children were evidence based, while higher numbers of all groups thought that targeted interventions were evidence based (58% of all respondents). This uncertainty about the value of any routine health visitor contacts contrasts with the confidence respondents exhibited in their ability to target and to identify health needs. Most astonishingly the confidence in the value of routine visiting is not matched by any perception that routine visiting

is evidence-based. Respondents seemed to hold parallel beliefs that routine visiting is not evidence-based, while also strongly believing in its importance. A possible explanation for this dual viewpoint is that respondents considered that routine visiting can be worthwhile although there is no evidence-base, whether because evidence has not been found or no research has been done to demonstrate the evidence.

Health visitors put most faith in the evidence-base for public health work. Managers conversely considered there was a more evidence for targeted visiting than for health visitors' public health work. Just over a third of managers considered universal developmental screening evidence-based, in contrast with over half of health visitors and 'other practitioners'. This supports the idea that managers' views tally more closely with government policy, while health visitors and 'other practitioners' continue to have more traditional ideas about health visiting practice. However, it should be noted that none of these differences between job groups reached the level of statistical significance.

4.8 Free text comments

Free text comments were an important component of the survey. They allowed respondents to make comments beyond what had been asked in the questionnaire. This meant that new insights on the phenomenon of the CHPP policy change could be gained, beyond what had been included in the questionnaire. This was invaluable for designing the next stage of the mixed methods study. The space left for free text comments also allowed respondents to communicate with the researcher about the process of research, for instance whether they considered it worthwhile or not. Where respondents had not been able to answer questions they had the opportunity to explain why in the free text space, and also to state where the questions had not reflected the subtlety of their opinion.

4.8.1 Who made free text comments?

Over three-quarters (84%) of respondents made free text comments. This indicates the interest of respondents in the study and also that they had more to say than was possible within the questionnaire. For both the initial distribution of the questionnaire and the reminder questionnaire the majority of the free text comments came for the South East region (20%), reflecting the higher number of returned questionnaires from the South East. Numbers of free text comments throughout all UK regions generally reflected numbers of questionnaires returned.

It was interesting to note that while numbers of free text comments from managers roughly corresponded with numbers of questionnaires returned, twice as many 'other practitioners' made free text comments (18%) than completed questionnaires which were then eligible to be included in the study (9%).

4.8.2 Summary of free text comments

Free text comments were highly diverse in content. Some were unrelated to the subject of the survey and gave further information about the respondents, for instance, whether and where they were working. These were sometimes useful in making decisions about inclusion, most commonly when a respondent identified herself as 'retired' in the preliminary questions, but was still working part-time or as a bank health visitor and therefore eligible to take part. A second group of comments focused on the questionnaire, the majority favourably ('thanks for doing this piece of work'), but others unfavourably. Many respondents did not like answering questions which forced them into an unequivocal response, such as agreeing or disagreeing with statements. A few respondents objected to the subject of the questionnaire, saying that I was exploring too small an area of health visiting work, and one that was less valuable than other parts, such as public health, infant mental health or child protection.

Of the comments that did focus on the CHPP these were both favourable and unfavourable towards the changes in policy. Some fully supported these changes, believing that in the past health visitors have had too much freedom to practise as they please. Many stated that economic realities meant that in future the health visiting service must be targeted to those with high needs, while children and parents with less acute health needs could be seen by less highly-qualified team members. Some of the respondents who favoured a pared down CHPP objected to my distinction between routine and targeted visiting. They argued that as all parents are offered a health visiting service until the child is school aged, which they can access according to need, this represents the continuation of a universal service. They also considered that as parents could request reviews at traditional ages, this meant that such reviews were offered universally.

Favourable comments often described a process of consultation prior to CHPP reform, where health visitors were closely involved in deciding on the content and structure of the programme. In some of these cases a local decision had been made to retain a more comprehensive CHPP than specified in the NSF for Children. This was said to be because local evidence from practitioners concerned with children (for instance, speech and language therapists, school nurses and paediatricians) suggested that more preventive contacts were needed to prevent late diagnosis of problems. Where respondents commented favourably they generally appeared to have relatively high levels of autonomy in choosing how they worked.

Unfavourable comments on the reform of CHPP policy were far more common. The most common points are presented below.

- Many respondents referred to the difficulties of forming a relationship with families when their contact is minimal. Child protection specialists

commented particularly on the importance of this relationship, and the important role of health visitors 'knowing' a family when there are child protection issues arise. Health visitors who work in areas with high health inequalities and with families from ethnic minority groups (particularly refugees and asylum seekers) commented that gaining the family's trust is a pre-requisite of being able to work with the family in order to meet their health needs. It was often stated that the most vulnerable are generally the most reluctant to attend groups or access services for themselves.

- Comments on targeting often included a comment on, 'How can health visitors know who to target if they have rarely seen the family?'. Respondents considered that families can move in and out of vulnerability, and families from all sorts of backgrounds experience problems such as post-natal depression, relationship breakdown, domestic violence, and child-related problems such as behavioural issues. Many stressed that CHPP contacts encompass the whole family rather than being narrowly focused on child development, and health visitors are often called upon to provide information about diverse issues, such as welfare benefits or contraception, and how to access appropriate services. Many health visitors said that they considered their work with families as part of public health work which feeds into work with the community as a whole.

- Many free text comments gave a picture of a service bedevilled by vacant and frozen posts, low staffing levels and low morale. In these circumstances children's and parents' needs had to be matched to the resources available, rather than practitioners being able to respond to all needs in the way they would have wished. Often there were inadequate financial and other resources to carry out public health work, even though many health visitors were keen to get involved in

this. Public health work was seen by many as the future of health visiting. Many practitioners commented on what a worthwhile job they felt they were doing, among people who rarely access other preventive services, but that the health visitor's role is being eroded. Health visitors' skills and knowledge are not used to the full because of constraints on practice, such as lack of resources and loss of practitioners' autonomy.

- Most health visitors stated that changes to their Trust's CHP programme followed the fourth Hall report and the NSF for Children. Some felt that health visiting had been evaluated according to a narrow 'medical model' without sufficient appreciation of the psychosocial aspects of health visitors' family-focused work. Respondents would like to see more research into the evidence for routine health visiting from a wider perspective of 'evidence', in order to show the worth of their practice. Many commented that changes to the service have been driven by cost-cutting measures rather than a clinical evaluation of a need to reform CHP. This comment was made by some managers as well as practitioners.

Free text comments proved very useful in giving pointers for areas of investigation to be pursued in the interview study.

4.9 Summary of Phase I findings

The survey was successful in providing a snapshot of practice across the UK. National policy changes have led to the widespread revision of local CHPPs across all regions of the country, but respondents' reports of local policy do not consistently reflect the recommendations of national policy, as described in the National Service Framework for Children, Young People and Maternity Services (DH 2004a). It appeared that a variety of CHPPs are in operation in the UK, differing in terms of numbers and type of contact with

pre-school children. Large numbers of health visitors have continued to offer a more comprehensive service to children, with a greater number of face-to-face contacts than recommended. The refocus of child health promotion to increased targeting of children with a specific need does not appear to have been uniformly translated into local policy.

Many respondents believe that children and families benefit from a higher level of universal contact than is proposed in the core programme. In addition, there are indications that practitioners perceive more need among their clients than anticipated by policymakers, making targeting according to need problematic. Many health visitors have views about the CHPP which suggest that they are not 'on board' with the changes; in other words, they view them as imposed from outside and as not according with their belief about what is good practice in child health promotion for pre-school children and their families.

There are complex reasons for the child health promotion policy-practice gap in the UK, which are beyond the scope of this survey to explore fully. From the survey findings it was difficult to ascertain the extent to which the divergence between national policy and local practice stems from health visitors practising as they choose, in contravention of policy, or whether local policy in itself does not follow national policy. The findings also suggest a gap between how managers and health visitors perceive that policy is being carried out.

4.10 Moving on to Phase II

Further questions arose from the survey, both from the questionnaire results and from the free text. While the survey identified these areas as being significant, insufficient detail could be gathered using the survey methodology to fully understand the CHPP as it is practised by health visitors within their daily work. The questions arising from the survey formed the

basis of the topic guide for the interview study, allowing issues of importance to respondents but not necessarily anticipated by the researcher, to be explored more fully a part of a part of qualitative enquiry. Some key points which were further investigated in the interview study are listed below:

Local policy on CHPP

- To what extent, and how, does national policy influence local policy and health visitors' practice?
- Do health visitors perceive a difference between local policy and what they deliver?
- To what extent can health visitors choose how they practise?

How is the CHPP implemented in practice?

- What part does routine visiting play in identifying and meeting children's health needs?
- Why is targeted contact sometimes not found to be effective in doing this?
- Is home visiting an important part of the CHPP?

Assessing need

- How do health visitors use the CHPP to identify and meet children's needs?
- How do health visitors target children with the greatest health needs?
- What part does professional judgement play in assessing need?

Chapters 5 and 6 present the findings from the nested interview study. The interviews did shed light on the areas outlined above, and were useful in bringing together issues raised in free text comments, such as resource allocation and NHS reorganisation, which had not initially featured as a main focus of the study. These illustrated the wider structural and political influences upon CHPP reform and implementation. As has been described in chapter 3 (section 3.4.1), the focus on health visitors working in areas of

urban and inner-city high need showed how the targeted programme operated in providing a service for the children who stood to gain most from such an approach.

Chapter 5

Interview findings I: the CHPP and health needs

These findings will be presented using the conceptual framework which emerged from the qualitative data analysis (see section 3.4.6.1). It explores three main themes: children's health needs, available resources and organisational change. These serve to demonstrate health visitors' views on the CHPP reform, in particular the significant move to a more targeted programme, and how this has impacted upon health visiting. Setting their views within the context of health visitors' preventive work makes clear the impact of wider structural and political influences.

Before presenting the findings according to these thematic areas, I will set the scene by describing the interviewees. After discussing the health needs of health visitors' clients, I will then move on to the central theme of the child health promotion programme (CHPP). This section will show what CHPPs health visitors describe themselves as delivering, their views on the value and purpose of the CHPP, and how the process of change came about. The remaining two themes, resources and organisational change, are discussed in Chapter 6.

5.1 Who were the interviewees?

Demographic details were asked of interviewees. Although it is not the aim of qualitative research to be representative, it is interesting to consider how typical interviewees were of the general nursing and health visitor population. That all the interviewees were women corresponds to the figures provided by the Nursing and Midwifery Council which show that all but 1.5% of health visitors are female (Nursing and Midwifery Council 2007). The average age of interviewees is similar to the average age of a nurse, as the most common

age group for nurses is between 40-49 years (35%). Interviewees had more professional qualifications than the average nurse; when last recorded (Nursing and Midwifery Council 2005) only 2% of nurses were registered on three parts of the old 15 part register, but over half of interviewees would have been registered on three or more parts of the old register. Statistics do not exist on how many health visitors are also specialists, team leaders, or union representatives, but it can be surmised that interviewees were in general more highly experienced and with more additional responsibilities than the average health visitor. All interviewees were from England.

Characteristics of volunteers are summarised in table 5.1 below.

Table 5.1. Characteristics of interviewees (n = 25)

Age	average age 48 years (range 33-59 years)
Sex	25 x women
Ethnicity	20 x white British 2 x white European 1 x black African 1 x Anglo-Indian 1 x refused to state ethnicity
Length of time qualified as HV	average 18 years (range 1-33 years)
Highest academic qualification	19 x BSc/BA 5 x Diploma of Higher Education 1 x MSc
Professional qualifications	25 x Health Visitors 25 x Registered General Nurse 11 x Registered Midwife 4 x Intensive Care Diploma 3 x District Nurse 2 x Registered Sick Children's Nurse 2 x State Enrolled Nurse
Job title	16 x HV 3 x HV team leader 3 x Sure Start/Children's Centre HV 2 x HV & union representative 1 x specialist HV
Hours of work	13 x part-time 12 x full time
Geographical location in England	6 x South West 5 x South East 5 x Midlands 4 x London 3 x North West 2 x North East

The majority of interviewees had a defined caseload, mostly of pre-school children living in a specified geographical area. If the caseload was 'geographical' then health visitors were responsible for all children 0-5 years in the locality, whereas if health visitors were 'GP attached' they mainly saw children and families who were registered at a GP surgery, though maintaining responsibility for any pre-school child living in the defined locality who was not registered with a GP. The caseload could be individually held, or a corporate caseload. In a corporate caseload one or more other health visitors shared responsibility for the caseload population.

Exceptions were the three Sure Start health visitors, who saw people who attended Sure Start centres, and the specialist health visitor for gypsies and travellers, who made contact with all travellers with children, by the roadside, on sites or housed, across the county. None of these had a specified caseload, but attended to presenting needs.

Many interviewees had additional roles to preventive health care for pre-school children and their families. Sometimes this was because there was a long established additional role for health visitors in the locality, for instance home visiting for the elderly, or because health visiting was being developed locally in new ways. Extra services being provided at the time of interviews included health promotion for adults, health checks for the over 75s, home immunisations for the housebound, TB port inspections, team working with school nurses, specialist child protection with social services, running a contraceptive clinic and providing triage in an Accident and Emergency department. However all interviewees saw these as additional to their central health visitor role of providing a preventive health service for pre-school children and families.

I have followed interviewees in describing the children and families with whom health visitors worked as 'clients'. During interviews it became

apparent that although client usually denoted every person to whom the health visitors offered a service, in practice clients usually meant parents, and children were just called children.

5.2 The clients

Appendix 5.1 gives an overview of how interviewees described their caseload. Almost half of interviewees said that their clients were primarily young, often teenage, and many were lone parents. Most health visitors reported that clients originated from a wide variety of ethnic groups, but around a third had caseloads which were almost exclusively made up of White British children and families. Some BME groups were long established residents, such as Afro-Caribbeans in London, or Asians in the North West, but many were non- English speaking new arrivals, either from Africa or Eastern Europe. A fifth of interviewees provided health visiting services for asylum seekers and refugees. Many health visitors described themselves as acting as a bridge to other health and social services for clients who might be 'invisible' to other services. Such clients included children and families not registered with a GP, immigrants and temporary residents.

Around half of interviewees described their caseloads as socially mixed, either because there were 'pockets of disadvantage' in an otherwise more affluent area or because the inner cities in which they worked were increasingly becoming populated by the middle classes. Therefore although the research was targeted towards health visitors working in the areas of highest health inequalities, in reality many interviewees were working with children and families with a mixture of health needs.

5.2.1 What are clients' health needs?

Health visitors' brief descriptions of the health needs of their clients are included in appendix 5.2. Almost all interviewees mentioned wider structural influences such as poverty, unemployment, poor housing, poor public

transport, low educational achievement and social exclusion, as well as specific health needs in families. Parents were described as having problems with alcohol and drug misuse (n =9), domestic violence (n = 9) and mental health (n = 7). Five health visitors described parents having abusive childhoods themselves as a significant health need. Generally health visitors gave more information about the health and social needs of parents than children, with more newly qualified health visitors most likely to mention parents' acute health and social problems rather than the common needs of children as they grow up. Children's health needs were most commonly described as child protection (n =9), with poor diet and behavioural problems also mentioned by most. Some health visitors considered the problems experienced by their clients as typical of all families, but exacerbated by adverse circumstances;

> 'Mostly they've got the same needs as the majority of the population but they're a relatively younger type of family. Maybe more stressed by other factors in society, financial factors, things like racism and social isolation within communities.'
> Maya, London[41]

Several interviewees mentioned that due to social disadvantage and previous life experiences clients are sometimes reluctant to engage with health professionals.

> 'Often there's a very poor background to the mums, they've been in care themselves, they've had poor upbringings themselves, there's been domestic violence, all that kind of problem which actually is very difficult to bring yourself out of…You've never known any better, have you, or any different? So people are very angry sometimes…they don't want any interference in their lives.'
> Ruth, North West

This increased the preliminary negotiation and relationship building work that health visitors did with clients before progressing to identifying and addressing health needs.

[41] All names have been changed throughout.

5.2.2 How is need identified?

A small number of health visitors said that a system was in place where need was examined across caseload by health visiting management or the public health directorate, which allowed staff to be allocated according to the needs of the area. For the majority of interviewees need was defined by themselves, at an individual level, rather than according to the level of social and environmental need identified in the area. Many interviewees disagreed with identifying need solely at the individual level, and commented they would like to carry out community health needs assessments. Newly qualified health visitors often felt that the public health skills learnt during training were under-utilised:

> '[you should] do health needs assessments in the community and really find out what the core needs are and just start implementing things, to act as a catalyst for change to improve people's lives...long term I think you're looking at communities and health needs, and health inequalities...and how we can do that with the financial situation as well.'
> Megan, South West

Most identification of need took place as part of the CHPP, during a routine contact or visit. When evaluating health needs at an individual level, a variety of methods of classifying and evaluating need were used. The majority of health visitors used a health needs assessment tool at a routine CHPP contact, antenatally or at the new birth visit, and then often repeated around one year. Rather than health needs being immediately obvious to health visitors, a process was described by which the health visitor gradually got to know families, and during which health needs emerged as part of growing familiarity with the family:

> 'Quite often that's how I begin to work families, by looking at what is actually happening, because there's so many things happening that you might need to start doing a little bit of unravelling to try and see which health needs you're going to, you know, address first.'
> Siobhan, North East

Experienced health visitors were more likely to describe the identification of health needs as a complex procedure requiring a period of getting 'alongside' the family before any judgments could be made.

5.2.3 A hierarchy of health needs

Some health visitors suggested that a hierarchy of health needs existed among clients, by which some clients' needs were seen as more valid to be met than others. Although there was an avowed intention to direct services to those with the highest health needs, in practice this proved difficult when clients were either invisible or unattractive to other services. Health visitors, as the sole agency involved in families, sometimes had a struggle to meet the needs of clients. An extended example illustrates this point:

> 'We had one little boy who came over from the West Indies, a very, very poorly child, microcephaly, and all sorts of conditions, and the mum was only here on holiday, she didn't have a leave to stay here at all. But she did stay here…he was three years old and weighed ten pounds the first time I saw him…I just went to do a visit because the grandmother had said her daughter-in-law had come with this baby and he was a bit down, and I thought, Down's Syndrome. And I was expecting a little three-year old with Down's syndrome, and I was just shocked. But it was just so difficult to get services. They weren't eligible for GP services and all the things you would normally put in place…and…I can't tell you the hours trying to [get services] well they won't do it, they can't provide it, no, they're not…and I basically had to emotionally blackmail the GPs to take the baby on and once he'd got a GP then we could look [for services]…but we were so restricted as to what we could give them because of this…and she was a bit cagey because she was here really illegally, and persisted to be here illegally. But as I said to the GPs, 'When you're sitting in somebody's living room how can you not do what you feel needs to be done?', and I think that's the difference. It's easy if you're on the end of a phone to say, 'It's not my problem', but when you're sitting in that living room you can't not, and that happens all the time. It's real people out there isn't it? They're not statistics and they all want the same things for their children whether or not they can provide it.'
>
> Vanessa, Midlands

Here the health visitor makes plain the raw urgency of the child's health needs. Being in the home meant that she could not ignore the problem, and she had to forcefully act as an advocate for the family, and persuade the GP to take on the child as a patient, despite the family being illegal immigrants. Instrumental in persuading the GP to take on the child, was their pre-existing good relationship. This example also illustrates that meeting health needs

does not always result in a positive outcome, or one which can be easily measured. Despite the subsequent inevitable death of this child, the health visitor considered that because the child received care (the child had treatment and died in a local hospice; the health visitor attended the funeral which was laid on by the local West Indian community), this contributed to the mother feeling that the best had been done for her child.

5.2.4 Do health visitors meet clients' health needs?

Most interviewees believed they were able to provide a very important and worthwhile service, which was well appreciated by clients. All health visitors said that the most inspiring part of their job was when they saw clients making changes in their lives:

> 'We actually go out and see the clients and you can see a difference sometimes'
> Hannah, South East

> 'I enjoy working with clients. I find that they give as much back as I give, because it seems to work; what we do seems to make a difference, it really does. Maybe it's because I'm in a more needy area, but I do see the change.'
> Maya, London

> 'I am quite low at the moment with the way I feel about health visiting; I'm more disillusioned than I've ever been. But sometimes, when you talk about what you do, you kind of realise that you do quite an amazing job.'
> Sam, North West

Given the high needs of some clients, health visitors counted very small improvements in individual circumstances as being major triumphs. A specialist HV for gypsies and travellers said:

> 'Even just to get somebody to a dental appointment, to have made that appointment, for that patient to keep it, and to know that you've moved that client one stage further on with their dental health, is hugely satisfying.'
> Alison, Midlands

5.3 The Child Health Promotion Programme

The remainder of the chapter is concerned with different aspects of the form and delivery of the CHPP.

5.3.1 What CHPP were health visitors delivering?

The various CHPPs described were diverse in terms of number and frequency of contacts, the extent of the universal service, and the ability of health visitors to provide the CHPP laid down in local policy. It was apparent from interviews that PCTs were at different stages of reorganising their programmes, so while some health visitors were confidently working with a revised agreed programme, others were in the middle of a process of change. The reconfiguration of PCTs meant that newly combined areas often had different CHPPs in operation:

> 'They've reconfigured into a big …PCT, so there's six PCTs gone together…and trying to get some agreement because every PCT is doing something different as their core universal programme… We're doing less than some other areas…so there's a bit of trying to agree on that.'
> Jane, Midlands

Appendix 5.3 shows what health visitors were delivering in comparison with what is stipulated in the NSF for Children (2004). All health visitors were performing primary visits, though in one Trust management were trying to give nursery nurses this role. All except one health visitor was carrying out a face-to-face contact at around 9 months. About half of Trusts offered a universal 2 year assessment, but only one health visitor carried out a universal 3 year contact. This was delivered with Book Start and immunisations as part of a local initiative. Few health visitors managed to deliver ante-natal visits, except on a highly targeted basis.

Interviewees were frequently unclear about whether their local policy matched national policy; a handful had not heard of the NSF for Children (2004) and did not know that a national programme was laid down. Two

health visitors in areas which had grasped the nettle in reforming the programme were astonished to discover that their local CHPP included contacts additional to those prescribed in national policy. The comparison between local policy and individual practice was further clouded by CHPPs being laid down in policy, which staff could not achieve in practice. One health visitor struggled to describe an entirely theoretical CHPP (she had been a member of a working party to devise it), which had been adopted as the local policy but had never been put into practice due to staff shortages. This lack of clarity about both national and local policy on CHPP made it difficult to make any simple assessment of whether local policy did follow national policy, and how this matched with what health visitors did.

What health visitors actually provided under the CHPP was very fluid according to which local CHPP was currently in operation, how closely health visitors had to adhere to this, and the needs of clients. Demand for services fluctuated according to current birth rates and level of child protection, leading to health visitors prioritising on a daily basis to manage the balance between the demands upon the service and their ability to meet them.

5.3.2 Why is the CHPP important?

5.3.2.1 Universal access to the child and family

The core CHPP programme was seen as a prime means of gaining universal access to children and families. The majority of interviewees had a clear sense of a core local CHPP which had been agreed within the trust and which provided the basis of their work; this was both as an initial access to clients and a means of beginning the process of identifying and addressing health needs.

> 'It's the core to how we approach the clients, but it's the kick-off point for an awful lot of other things, because of what you identify through that; you then meet the needs of the clients, and meet what they identify as their needs.'
> Jenny, North East

The core programme defined which contacts and interventions health visitors carried out as part of the CHPP, and for most health visitors provided the expected way of working in that area. In some areas the core programme had been used in a more formal way as the basis for a service level agreement. Almost all interviewees stated that the core programme had been defined and revised within the last year or two, sometimes as a result of PCT (Primary Care Trust) reconfiguration. Health visitors were very aware that the CHPP in operation in their area was often location specific, as they knew health visitors in other part of the country, or heard at conferences, that the extent of what was offered, particularly the universal service, varied according to area.

The CHPP as a whole provided a structured and well accepted framework of contacts which provided an initial 'way in' to the family. The 'health' status of health visitors was a very important part of this process, as was the fact that the programme was directed towards children:

> 'Health is not seen as being discriminatory or condemnatory, and whatever they think for themselves- and a lot of the mums we deal with have very low self-esteem - they will do whatever they can for their children. So if we're offering them something for the children we can usually broach general public health at the same time, and it's a wonderful foothold in.'
> Jenny, North East

The CHPP provided a structure by which parents expected to have contact with the health visitors. Even health visitors working in the poorest areas described clients as expecting their children to be seen at key stages, and wanting to know how their child was 'getting on'. Most thought that the CHPP was well accepted by parents, even those who accessed few other services. Two interviewees thought this was because parents were under the misapprehension that the CHPP was compulsory. Individual one to one appointments, in the home, were described as most liked by clients, with the highest uptake; where CHPP contacts took place in a group at a clinic, clients were reported to be far less likely to attend.

Universality of access was seen as crucial by almost all interviewees. As an established universal service they saw themselves as having access to clients which other services do not have, but which, however, cannot be taken for granted:

> 'We are going into all families, there's no stigma attached...there's no association of, you're a bad mother if your health visitor's visiting, and I think that's a huge thing. And just the ability to build up a relationship, that parents can feel they can approach you and ask for advice without being stigmatised….in the area I work, there is a kind of trust in the health services but you can't maintain that if you're not good at building up relationships with families.'
> Sam, North West

Visiting at home provided an opportunity to see clients in their own setting, which gave insights into living conditions and also family dynamics. Several interviewees commented that even watching a mother undress her baby for weighing was instructive in showing the quality of mother-child interaction.

5.3.2.2 Making a relationship

All interviewees saw the new birth visit as being particularly important in providing the foundation of a relationship between the health visiting service and the family. If a contact could be made at this point it would pay dividends for later contact with the family. One health visitor described very clearly how even at the initial stage of talking to parents about the normal development of the child, she saw herself as paving the way for further contact if problems should occur :

> 'Another thing which I do an awful lot around when I do visit with families is about communication with their child. So with a baby, 'Have you been playing face games?'.... and they go, 'Ooh what do you mean? He's only newborn'. I say 'Well, if he's chilled out you can pull your tongue out and see if he copies', and they go, 'Hey love, we tried that, his dad said I was talking a load of rubbish but his dad got him doing it, he's amazed.' So that sort of side of things. So right from the word go they realise their child is listening to the world, which I find particularly important when you've got a feeling there's domestic violence going on, but very much about building that relationship with the family, so that if they have got a problem they'll

> pick up the phone and they'll go, 'Bev, you know, he's had me up against the wall by my neck and threatened to kill me.'
> Beverley, North West

An important part of the initial contact was to gain the trust of the client, and ensure acceptance for the service. This involved in many cases a subtle process of negotiation, which began with the health visitor engaging first with clients' self-perceived needs rather than any official agenda. Almost all interviewees spoke of engaging with the clients' agenda, before attempting any health visitor inspired health promotion interventions. This was most forcefully presented by the specialist HV for gypsies and travellers:

> 'You don't do– this is one of the big things– you can't do any work with them until you're respected. So it's not good going in on your first visit and criticising them for something, because you won't get in again, and that's the end of the story. So you've achieved nothing. So you have to attend to their agenda always, it's their agenda. And if you don't do that then they will say to your face, well you're rubbish.'
> Alison, Midlands

One interviewee described the health visitor-client relationship as 'befriending' though was unsure that this was the right term. Most interviewees agreed that the relationship was characterised by the health visitor showing respect and friendliness towards clients, and being prepared to give enough time to establish trust. Often health visitors described themselves as being well known figures in the local area ('we're quite visible, people know your car…they know you've been next door to see so and so'[42]), as well as being known to individual families.

5.3.2.3 Health promotion

The same issues of negotiating a relationship arose in relation to health promotion. Health visitors agreed on the sort of information and advice they were giving, which was predominantly that described in the NSF for Children. However, they did not see giving health promotion advice as a simple

[42] Diane, South West

process. First of all the advice had to be presented in a way acceptable to the parents:

> 'The sort of health promotion that I tend to be doing is very much looking at feeding advice, mental health advice, safety advice, all those sorts of things, but doing it in such a way that somebody doesn't tell me where to go, because…most of my clients are very down to earth and will quite happily tell you to f*** off if you're bothering them, you know, 'Who the f***ing hell do you think you are coming through my door?' sort of thing. So we've got to be very subtle with it, if they're smoking, 'Have you thought about smoking outside of the room?'
> Beverley, North West

Secondly, simple advice giving about health promotion issues was seen as a pointless activity if a family were struggling with difficulties which affected their ability to follow such advice. In this case only more long term work with the family, to deal with entrenched issues such as domestic violence, would create the environment in which smoking cessation and improving diet could be discussed. Poverty in itself was recognised to be a barrier to families improving their lifestyle:

> 'If you've got a poor income- and I know we say they shouldn't smoke and this that and the other, but they do smoke, don't they?- if you've got a poor income…it's all right for me to say you should eat five a day and you should stop smoking [but] if they're suffering domestic violence, if something's really ingrained it's actually very, very difficult to change, and me going in on the short term giving advice, actually I don't think makes a lot of difference.'
> Ruth, North West

Thus while the CHPP was seen as an important vehicle for engaging families in health promotion, effective health promotion could only be carried out once the health visitor had been accepted by the family, and within a two-way understanding and appreciation of the family's particular circumstances. Many expressed the view that it is impossible to change the living environment of a child, without first of all addressing the parents' problems.

5.3.2.4 Assessment

Most health visitors described carrying out assessments of families' health needs at key points in the CHPP, usually at the first contact with families

(antenatal visit or new birth visit) and before one year. Many health visitors were aware that the NSF for Children had stipulated an assessment of the child's well being and the family's needs by one year, and as result the local CHPP had been amended accordingly. Some interviewees spoke of using assessment tools to assess need, while others conducted a more informal assessment, relying on their 'professional judgment'. At one level assessment could be a relatively unproblematic procedure:

> 'I think we need universal primary visits to begin with, to be able to glean whether families would have to be targeted, so [we can do] specific health promotional aspects, and other services and other input.'
> Natalia, South West

Some interviewees objected to assessment tools which attempted to shape this process. Several felt that clients rarely answered assessment questions honestly, especially at a first contact. Two health visitors described assessment questions as very stark, requiring the health visitor to ask about substance misuse, domestic violence and childhood experiences. One was concerned about the emotional impact upon parents of such an in-depth assessment, especially when they may never see that particular health visitor again. Some perceived a growing overemphasis upon assessment to the detriment of actually working with and supporting families:

> 'I think that our managers seem to want us to go in and do an assessment and then hand everything over to anybody else really…whereas I actually enjoy that one-to-one trying to work with the family, and try and work through some of the issues, but our own manager ….gives you the impression you should be handing everything over to everybody else….I can't see the job satisfaction in that really.'
> Frances, South West

Some health visiting teams worked to a local policy of the health visitor making the initial assessment, for instance at the new birth visit, and then any follow up being provided by the less highly qualified team members, such as staff nurses or community nursery nurses (CNNs). In one area this has become well established and the interviewee had got used to working in this way, but other health visitors found that the change of worker made it

more difficult to establish a relationship of trust, and resulted in less familiarity with clients.

The family health needs assessment would contribute to the decision as to whether the family needed to be targeted for further health visiting team contacts, or whether the family could have the routine service of the local CHPP. Dissent about the assessment aspect of the CHPP focused not on the fact that an assessment was carried out but the means by which the assessment was done, and the role of the health visitor in continuing to work with the family after the assessment was done.

5.3.2.5 Developmental assessment

The NSF for Children does not include developmental assessments in the recommended CHPP; however these were commonly carried out as part of local CHPPs in operation. There was a wide disparity of views between health visitors on the worth of developmental assessment. Some health visitors saw the prime reason to carry out the CHPP as being to take an objective look at the child from a standpoint of experience, and identify any problems. There was an awareness that this aspect of the CHPP was under threat and no longer valued:

> 'I know the writing's on the wall, but I think that in reality somebody needs to cast an eye over them, somebody who knows what they're looking for.'
> Theresa, London

> 'Everybody gets a developmental assessment because I'm a trained nurse and a midwife and I've done lots… I've seen hundreds of babies and quite often I think they would benefit by having the once-over from me or somebody of my qualifications…you know, why shouldn't our children have that? Why should they be passed down to the lowest common denominator or just a questionnaire because there's only so much money? Other things… aren't clinically proven; if I ever got hold of Hall I'd give him what for.'
> Siobhan, North East

Newly qualified health visitors were more likely to say that CHPP contacts are an opportunity to discuss with their parents their observations and

concerns about the child, and were more critical of the idea of carrying out a formal developmental assessment. Identifying problems was not seen as a skilled activity to be carried out only by specialists:

> 'For goodness sake, can't we trust the parents a bit more? Some colleagues don't seem to for some reason, and I think that is a training thing because these colleagues I'm talking about trained 20 years ago…And is it relevant to be going to be doing tick-box things? I question, you know, is it relevant? As soon as you walk in the door you can tell if the child's not the full ticket!'
> Bridget, South East.

However simplistic lines cannot be drawn between the newly qualified and the more experienced, because some from each group were in favour of not seeing children after the one year assessment. Those in opposition to routine checks after one year felt that if families knew the health visitor they would make contact if necessary, and, when children were in day care, early years workers were well able to pick up problems. Another group of interviewees did not share this view, and were concerned that if children were not seen at two years, and even three years, problems would be missed. Many health visitors described conditions they had picked up, ranging from congenital dislocation of the hip, to sight problems, to autism, which would otherwise not have been noticed until the child started school.

Developmental assessments were often carried out by community nursery nurses (CNNs), because it was considered that their experience and knowledge was about the development of children. In cases where CNNs had been introduced to teams as a local policy initiative rather than at the request of health visitors, developmental assessments were sometimes seen as a way of making use of CNNs, when health visitors were uncertain about what other aspects of their work CNNs could take over. Generally healthy visitors were impressed by CNN skills in child development, but some expressed concerns that they focused on the child to the exclusion of the

parent, and that they could not cope when additional difficulties presented themselves such as domestic violence, depression or physical illness.

5.3.3 Who is the CHPP for?

Interviewees saw the CHPP as an intervention provided for the benefit of several different groups of people. The most common groups mentioned were children, parents and family, and service providers. The nature of the intervention, therapeutic or monitoring, varied according to who was currently seen as the recipient of the service. Most interviewees saw the CHPP as a flexible intervention which could be provided for different recipients at different times, so these groups should not be seen as exclusive. Some health visitors had more decided views of the role of the CHPP depending upon ideologies of what the health visiting service is for, and the relationship of the client to the professionals; these points are brought out in the sections below.

5.3.3.1 The CHPP is for Children

Those who saw the CHPP as being for children were generally firm proponents of the need to assess children regularly. This was seen by some as a child's right; in this case interviewees often compared the CHPP unfavourably with more comprehensive health promotion systems abroad. The majority of interviewees thought children needed to be seen because parents could not always be relied upon to identify children's health needs or seek help appropriately:

> 'In theory I sort of trust parents….on the whole but I do think, perhaps in our area I think parents quite often don't always understand, or actually know what a child should be doing at certain ages, so sometimes you can go and see a child and the parents perhaps might think the child's doing fine, but actually isn't.'
> Frances, South West.

Parents were described as potentially not noticing problems because they had insufficient knowledge about child development, low expectations of the

child, and because their own needs were so great that health was not prioritised within the family. Where parents did identify problems they could lack knowledge of how to access services, particularly if they were new to the UK or spoke little English.

Although many considered that the CHPP was for children, all were agreed that it was not compulsory; the child had to be presented by the parent, either at the clinic or in the home, for the contact to take place. Health visitors would try to make it easier for parents to access the CHPP by offering home visits, but where a parent repeatedly failed to comply, if there were no child protection concerns, then health visitors said they did not continue trying to see the child. Immunisations at home were offered by some health visitors. This was an interesting area where the rights of the child and the capacity of parents to provide health services for their child were played off against each other. Interviewees who carried out immunisations at home made clear that they perceived it a parental duty to bring the child to clinic for immunisations, but where the parent could not be relied on to do this, immunisations might be given at home:

> 'We do immunisations, sporadically at home, for example if a child is on the register and you know parents are not actually complying with the plan, where …you have written about three letters asking mum to come to the clinic and they still wouldn't come and given one excuse or the other, you might have to decide in the interest of the child to do it at home …but it's not something that we do routinely.'
> Olanna, London

> 'If we've got, say, somebody with a set of twins, a couple of other children, and transport's a logistical nightmare, we will do them at home. The last ones I did at home were child protection, when I just had a feeling that she wouldn't turn up for anything and was going to do a bunk, and I did all those at home.'
> Jeanette, Midlands

Sometimes health visitors could not immediately address the needs of the child without first of all engaging with the parents' priorities. Here a Sure Start health visitor describes a sideways approach to introducing the subject of a child's well being:

> '[It's] getting alongside a family and talking about whatever that person wants to talk about, the issue of the day, whether it be the debt or whatever, and then… gradually you come to why little Joey is looking a bit unkempt…[and] there are cat fleas jumping around.'
> Chris, South West

5.3.3.2 The CHPP is for parents and families

Almost all interviewees saw the CHPP as being for parents as well as children. Extreme examples of health visitors providing a preventive health service for the whole family were a health visitor doing blood pressure readings for adult family members at an initial contact, another referring a new father with a family history of bowel cancer for screening and yet another arranging for an Asian grandmother to have her first cervical smear. Although most interviewees did not describe themselves as carrying out such medical interventions, all gave instances of addressing parents' needs as a means of improving the health of the child. The most common of these was to screen and provide support for post-natal depression. Many health visitors described taking an empowering approach to mothers which began by simply listening:

> 'A lot of the women that we visit are quite vulnerable and they're used to being told what to do, and they've never been allowed…to explore what they really feel and what they really think. And…I've found that if I allow them to do that they solve a lot of the problems as they're telling you about it, and that is quite empowering for them.'
> Jeanette, Midlands

The CHPP was also seen as for parents in a second and less direct way, in that it gave a cover for monitoring and exploring parents' health needs at contacts purportedly set up for the child. Two examples illustrate this point. One health visitor felt sure that domestic violence was going on in a family, but could not discuss this with the mother, because the baby's father was always present, preventing private conversation. The health visitor insisted that continued home visits, ostensibly to the child, made it possible to for the mother to eventually ask for help:

> ‘She poured her heart out to me and she told me what was going on[43], but only because I was the one person she knew who continued to visit, who'd made… more visits than I would have normally, ‘Oh, can we talk about second stage weaning’, you know.
> Beverley, North West

In the second example the interviewee seems to suggest that both parents and health visitors prefer to work under the umbrella of providing a service for children, rather than making clear exactly what health need has been identified.

> ‘I would use an excuse like, ‘Oh, you’re almost 18 months, I’ll come and see you’, so that they don’t feel picked on…word gets round the estate and they’re very tight in this estate, so if the mother can say, ‘Oh, she only came to do the 18 month check’, rather than, ‘She came to follow up a domestic violence referral’, you know, it sounds better!
> Jenny, North East

Of course, this is only seen from the health visitor’s perspective, so it is not known whether, in reality, mothers prefer the use of the CHPP as a reason for health visitor contact, rather than an open admission of targeting. Some interviewees were ideologically opposed to using the CHPP in this way, and felt that health visitors should be open about their aims.

5.3.3.3 The CHPP is for service providers

There was a general agreement that the CHPP had never been solely a means of assessing children’s development, but always functioned a way of gaining access to the family in a well established and accepted way:

> ‘I think it’s useful to have that contact. We don’t always necessarily pick up huge amounts of things because parents have already brought it to our attention or we’ve already picked it up, but for some families where…we don’t see them very often, it might be the only time we get to see them and pick up if there are any problems, because they don’t access anything else regularly.’
> Jane, Midlands

[43] Reputedly maternal alcohol misuse, father threatening to snatch the children and domestic violence.

The CHPP was sometimes seen as being primarily for service providers, because it was a way of monitoring not only children, but their parents' parenting capabilities. Complying with the CHPP was seen as evidence of adequate parenting, not just by health visitors, but also by social workers. Most health visitors said that when a child in need referral was made, attendance at routine CHPP appointments was used by social workers as a way of gauging both the health of the children and the capacity of the patents to provide appropriate care. One interviewee said that when a child did not attend clinic for a check she would carry out the review at home 'in the interests of the child', but she would not submit the form as a completed developmental assessment. The reason for this was that if there was a subsequent social services referral, it was important to identify the parents as 'defaulters'.

One Sure Start health visitor saw the CHPP as being carried out for the benefit of health visitors, meeting their need to avoid change:

> 'Although it is now the general consensus that a letter will be sent, to my knowledge there are still many that go into many homes and do the two year review, even for families that are OK and there are no concerns over …I think somebody just needs to say it can't happen. We know the reasons why, we've seen Hall 4 and everything, and we know the reasons why perhaps it is not so important. I think it has been ingrained into them. It is how they have always done it.'
> Chris, South West

Team leaders described some health visitors, particularly those who had been qualified for several years, being reluctant to stop carrying out routine visits in line with the new revised programme.

5.3.4 Reform of the CHPP

5.4.4.1 Why did the CHPP change?

Health visitors attributed the changes to the Hall report, a lack of evidence for the CHPP and the need to make financial savings. All interviewees saw the

Hall report as a prime factor in leading to change. Most saw positive aspects to Hall's recommendations. These included increased emphasis on health promotion, a move towards public health rather than individual working, more intensive contact with the under ones, stress on empowering parents and providing a standardised service. In themselves the Hall reports were not seen by most as having a negative effect on the health visiting service. However, it was felt that the fourth Hall report had been seized upon by both government and PCTs as a means to reduce services and save money:

> 'Well I think it is, in fairness, about trying to tackle inequalities and trying to release the workforce to work with the most disaffected and….with people with the most compound and difficult health needs, and to stop that whole sort of perception of going around banging on doors for no apparent reason, and I think that would be the pure motive. And there may be a less pure motive about cost cutting and actually just snipping away at things. My concern is that the people who have made these decisions… people in positions of policy making, have maybe often got their own personal perspective which may be slightly different from our perspective, and I think one can go too far one way with…the bath water situation.'
> Kate, South West

Interviewees thought that Hall advocated change because individual surveillance had been shown not to pick up problems, resources needed to be targeted to those with the highest needs and it was not cost-effective to continue with a universal service which included routine contacts with all children after the age of one year. Some health visitors, particularly the more newly qualified, welcomed changes and anticipated future advantages for health visitors:

> 'There's been pushes to make changes, hasn't there?, from the traditional health, what I call tick-boxy, kind of one-to-one, 'I'll come and visit you next week, dear', to the more public health role that I think we're being encouraged to go into…it's not going to be an overnight process and it isn't easy for some people, but I think there's some nice things…to look forward to.
> Bridget, South East.

> 'I still feel very strongly that if you put it in in the first year, the parents will come to you…With my public health hat on, I would be much happier to get people motivated, so they know where to find me, rather than me running around finding them all the time.'
> Barbara, South East

Several health visitors argued that in reforming the programme according to principles of whether screening is effective Hall had missed the point that preventive health contacts were never just about checking children for abnormalities. Instead health visitors had valued the contact because it allowed access to the family and permitted health visitors to identify factors which were impacting upon children's health and well being, and to discuss these issues with parents and carers:

> 'I would agree with the fact that you didn't often come across a child with an obscure problem that nobody had identified before, but I didn't really see that as a point anyway. I felt it was a very important time to be talking about some of the more subtle and difficult areas of, you know, parenting.'
> Kate, South West

> 'We were given the understanding that developmental assessments…were not necessary any more because they weren't showing any delay, and things like that, but I think health visitors felt generally that, yes, they were giving a lot of other clues as to what's happening in the family, not necessarily that the child was delayed in development. Even though they were called developmental assessments, that really wasn't what was being assessed generally.'
> Maya, London

Interviewees felt that research on the CHPP had focused on the pros and cons of screening and by-passed health visitors' contribution to delivering the programme. Not enough research had been done which looked at the intervention from a health visiting perspective.

5.3.4.2 Who influenced policy change?

Changes to the CHPP were seen by interviewees as coming from national policy such as Hall and the NSF, and then translated into local policy by a process involving PCT managers, health visitor professional leads and sometimes practitioners. All interviewees described the impetus to change as coming from above. In some PCTs health visitors had been involved in the change, while in others it was imposed by management with very little consultation. Several interviewees described the change as being something

that was inevitable and could not be averted; if consultation took place this was at a level of deciding the details:

> Q 'How did the changes come about in your area?'
> A 'It was quite interesting in that it was pushed through very fast. In the past we've had various little changes, but nothing like this. And suddenly we're given a deadline and told it's going to happen then, leaving the team to get on with it, no talking. .. there was an ultimatum.'
> Jenny, North East

> '[We're] very much told…that we are whingers or we're…frightened of change…well, we have to do it, given no choice, it wasn't up for discussion, we had to get on and do it as best we could.'
> Karen, London

Most interviewees described the process as involving some consultation with staff about CHPP changes. The most common scenario was for working parties of health visitors to be formed which discussed changes, fed back to other staff, and then agreed on a final programme which was subsequently adopted. In some cases this worked very well. Interviewees viewed positively consultation where health visitors had the opportunity to freely debate changes; there was good communication between staff, working groups and management, and a perception of a 'bottom up' approach. By this process about a quarter of interviewees said they felt they had been able to influence the programme that was subsequently offered, and that they thought that the programme now offered was 'about right'. 'About right' usually involved avoiding 'over-visiting' well-children for no reason, but having the flexibility to make choices about where to provide enhanced visiting.

There were several examples of areas where this process had not worked. In two areas health visitors described a consultative system being set up, but subverted by management when working groups proposed a CHPP which did not match what the PCT wanted. In one case the facilitator of the group re-wrote the programme in a much reduced form after the working party had made their recommendations. In the other the recommendations of the working group were simply ignored and a different programme openly put

into place. In some PCTs those not in favour of change were in danger of being branded Luddites:

> 'Those who resisted it were accused of being sort of Luddites and obstructive to new ways of working.'
> Hannah, South East

> 'The sort of Luggets or whatever you call them …Luddites, yeah, they don't even bother turning up and arguing… and then when it has all been done then they have a big moan and groan, but don't change really.'
> Jess, Midlands

All health visitors agreed that there was little consultation with parents about the changes to the CHPP. One interviewee described a consultation group being offered to parents but this was on the other side of town, and parents were unable to attend. The interviewee contrasted this with Sure Start consultations where meetings had happened locally, and parents' views were valued. It was generally felt that there was no impetus to give parents a voice in this process. Some suggested that parents were not consulted because they might ask for a more comprehensive service:

> 'There's not a lot of user involvement, I think that's probably the shortfall, I think, in our service, that we actually don't ask parents historically…I guess because if we ask, they'd want more. I think that's the basic problem …if we did go out to public consultation, I think the public would say we want to see our health visitors more …want us to be more high profile.'
> Diane, South West

Conspicuous by their absence were other health professions or other early years services being described as having any influence on deciding the level of reform of the CHPP. Interestingly GPs were described as objecting to other aspects of the modernisation programme, such as health visitors being geographically based rather than GP attached (see Chapter 6), but were not described as having been invited to take part in consultation, or being moved to comment on CHPP reforms. The sole exception was one area where GPs who persisted in doing 9 month 'hip and heart' checks, objected to being told by the PCT to discontinue them.

Most reference to the views of other agencies came in the form of descriptions of comments they had made about the reform of the CHPP after the event. One interviewee said that a local community paediatrician had said to health visitors that the reduced programme had led to more unidentified problems. Several health visitors described other health professionals as having noticed that children were not being seen as regularly by health visitors; school nurses were described as saying that children came to school with more problems, and speech therapists that speech problems were not being picked up before school entry. Social workers were also described as being aware that children were seen less regularly on a routine basis, but they were described as being too short-staffed themselves to make any protests, and in any case, after a while, people just get used to a reduced level of service.

5.3.4.3 Did health visitors change their practice?

Not all interviewees had changed their practice in response to local policy. Where health visitors disagreed with reductions in the CHPP they sometimes continued providing a universal rather than a targeted service:

> 'I like to offer a full universal surveillance and target extra the ones that are problems, because if you don't see them you don't know if they've got problems anyway, do you?'
> Siobhan, North East

This health visitor prided herself on being able to continue providing a comprehensive CHPP by dint of hard work and strict organisation of an individual caseload. In this Trust, management seemed to leave individual health visitors to provide the level of service they felt able to provide. Where the service was stretched managers were likely to put pressure on health visitors to cut down on any extra contacts. Two team leaders explained that part of their role was to ensure that health visitors were sticking to the CHPP and not engaging in over-visiting of clients beyond what was stipulated in the

core programme. This surveillance extended to checking health visitors' diaries to monitor what visits they were carrying out.

The majority of interviewees went along with the core programmes because this was the service offered by the Trust. Those who objected to the changes generally said that they had no choice but to offer a limited service, because they could do no more. However, some managed as far as possible to bend whatever changes were proposed to the service they wished to provide:

> 'I think the smart ones amongst us are the ones who look at what we are … what is coming down, look at what we think the needs are, what we think we are good at, and just keep trying, and trotting on to do what we think is important really.'
> Kate, South West

Where a revised programme had been imposed without consultation, health visitors were more likely to refuse to change their practice. Here an interviewee describes her response to a recent email from the PCT which instructed health visitors to stop doing ante-natal visits and 2 year checks:

> 'It's just one more nail in the coffin, isn't it? Of whatever's going on in the community and … one more thing to think, 'Oh well, until somebody actually stops me from doing this…I'll do what I think is best'; I think that seems to be the way of it.'
> Paula, South East

A Sure Start health visitor, although a fervent opponent of old-fashioned extensive routine visiting, suggested that poor management of change by PCTs served to harden many health visitors' resistance to CHPP reform.

5.3.5 Targeting the CHPP

5.3.5.1 Who gets a targeted service?

At an individual level there were clear agreements about who would be targeted. Needs warranting targeting were very similar to the health needs of clients in general, namely: child protection, domestic violence, parents with

mental health problems, drug users, socially deprived people in general, which interviewees frequently considered to be most people in the area. A wider range of children's difficulties were described as triggering targeting; these included health needs such prematurity, low birth weight, physical ill health and special educational needs, as well as problems around eating and sleeping and children's behaviour. Health visitors described themselves as targeting people referred to them by other professionals and agencies, such as midwives and social services, and those who did not engage with services, or missed appointments for their children.

Parents could request a CHPP contact if they responded to the letters which were sent out in lieu of face-to-face contacts at 2 years and 3 years. This could be because of an identified problem, or simply a request for an assessment. Some health visitors perceived this as diluting the targeted nature of the service because often middle-class parents with low levels of health needs wanted this. No interviewee described themselves as refusing to see a child for a CHPP assessment at the parent's request, even if the child was known to be a low priority. Interviewees did not generally consider the system of sending letters as useful because those who most needed to see a health visitor were least likely to respond to the letter.

PCTs varied as to the robustness and clarity of the system set up to identify need. Some interviewees described a system for targeting, such as the A, B and C priority system described by an interviewee in the Midlands. After the 9 month assessment clients were categorised into one of the three groups, and the highest priority clients received an enhanced service, with a joint review every 3 months by the health visitor in conjunction with a supervisor. By contrast in most other places, health visitors targeted more informally according to their professional judgment. Some health visitors felt very happy with this, but others were concerned that this left them open to criticism. A few interviewees described themselves as under pressure from management

to provide service which targeted only the most severe need. One interviewee described antenatal visits being targeted to mothers under 16, and those who had previously experienced a sudden infant death.

5.3.5.2 Clients' responses to targeting

Where health visitors and clients have different perceptions of health needs, this presents an initial difficulty in discussing targeting services to clients with the highest health needs. Often clients' perceptions of their own needs did not accord with that of a health promotion agenda. One team leader described attempting to discuss with clients at the 9 months review whether they required a standard or enhanced health visiting service; clients rarely had a view on what kind of service they required. Health visitors generally agreed that, where clients are given a choice of whether to have enhanced health visiting, then middle-class clients and those with routine 'having a new baby' problems welcome extra contacts, but few others wanted it. One interviewee gave the following account of targeting:

> Q 'How do you decide who gets a targeted service?'
> A 'Well to be honest it's, I suppose, he who shouts loudest, or the things that become very obvious, people who you're visiting for other reasons, or people who respond to the letters, but not everybody does.'
> Vanessa, Midlands

Health visitors varied in whether they told clients whether they had been targeted. Some felt strongly that it was right to be honest with clients and not to address adults' health and social problems under the cover of the CHPP. Health visitors who had a system of presenting targeting, such as devising a care plan in conjunction with the client, appeared happiest with telling clients that they were being offered a targeted service. Some interviewees felt that those who were targeted generally had long standing problems and were used to health and social agencies involvement, so targeting was expected and therefore tolerated. A few heath visitors felt very strongly that if clients

were told they were targeted this presented barriers, and it was unlikely that parents would continue to engage with the health visitor.

> 'I don't think it's possible to target the most needy, they don't want to be targeted... they talk about transparency, being open with people and so forth, I've tried being transparent and open, people don't want to know, they never open the door again…so I find myself saying, 'Well, it would be lovely to see you again next month'…and glossing over the vulnerability, in order to keep the relationship going...As soon as they know that you think that there might be something wrong, then they simply opt out.'
> Theresa, London

5.3.5.3 Should services be targeted?

Views differed on the extent to which health visiting services should be directed towards those with the most extreme health and social needs. Several health visitors, even those who were vocal about the high needs of their own urban and inner city caseloads, emphasised that all parents and children had health needs.

> 'Just because you have a nice house, you have a job, does not mean to say that you're any less likely to suffer from domestic violence, you're any less likely to suffer from postnatal depression, I'd say you're probably slightly more likely to actually, if you're used to having control in your life and doing everything what you want when you want, and you've got to keep up with the Joneses and everything.'
> Beverley, North West

> 'You could argue that, you know a child whose…parents both work sort of all hours of the day, they might be very high flyers but…you know, the child never sees the parents, could be just as emotionally deprived as some of the children I work with'.
> Frances, South West

Both these health visitors used the argument of universal need, to defend providing a comprehensive, universal health visiting service. However other health visitors, particularly team leaders, were more prepared to grapple with the issue of how to allocate a limited resource to meet the needs of a large population. One team leader explained the targeting of services as a rational response to the limited capacity of services:

> ‘If I was offering everybody the same level of service one of two things would happen; I’d get complete burnout or… I just couldn’t do it. And we’re not all equal….and we’re not all entitled to the same levels of anything, and it would be unethical of me to offer the same level of service to an articulate, very vocal, middle-class mother, versus an 18-year old that can’t read and write and doesn’t know where to go with a baby…I think we’ve always done it, to be honest. It’s just that this has made it open and transparent, or whatever you want to call it.’
> Jeanette, Midlands

> ‘I think we, like in the area that I work in, we realise that we cannot reach everybody, you know we have to actually focus our efforts, because some of the children that we work with are very, very needy, so the others really have to fend for themselves a little bit.’
> Diane, South West

Within the caseload, a process of prioritisation had to take place in order to direct what health visitor time was available to the clients with the highest identified health needs. In some cases health visitors felt that they were only able to prioritise the most severe levels of need due to time and resource pressures. Where there was a need to prioritise services, children in need of protection were always considered the highest priority.

5.3.5.4 Targeting and child protection

The new emphasis on targeting frequency of contact and level of service to those with the highest need was an area of potential conflict between practitioners and managers. Most areas did not have a system of supervision for reviewing clients with high health needs, apart from the system of child protection supervision. Where staff were allocated to high priority areas according to need, there was a tendency to allocate according to identified child protection concerns to the exclusion of other needs. A health visitor working in the North West complained that because her Asian caseload scored low on child protection, higher numbers of staff were not allocated to the area despite otherwise high health needs.

Even with regard to child protection, most interviewees described a lack of organisation and clarity about the process by which high priority cases were

either identified or reviewed, leaving health visitors at a loss to know which clients to target and what level of service to provide. Here a health visitor, working in an understaffed Trust, describes pressure from a child protection supervisor to fit the level of need to the ability to provide a service:

> 'I think our standard [for visiting vulnerable families] is once, well it should be once, every three months…And child protection supervisors are aware that we are not in there doing that, and what they want you to do is say, 'OK, well if they are not raising their heads, then you have got to downgrade them.''
> Naomi, South East

Some interviewees described the move towards targeting as leading to increased fear of repercussions if a potential child protection concern was missed. This was shown most prominently in the case of a child who was seriously harmed by a male family member. The child's mother had been targeted as a result of a health need, but the child was not identified as being at risk. Following the incident the family health visitor was subjected to disciplinary procedures because she had failed to identify the child's health need in addition to that of the mother. The interviewee felt this was unfair because there was no general agreement on whether to target the children of targeted mothers, and the risk to the child could not have been predicted. PCTs' stance on health visitors' management of child protection cases was described by several interviewees as increasingly punitive, with health visitors at risk of being held personally accountable for failures to protect children:

> 'The stress of getting it wrong is drummed into us, we have these serious case reviews…where they go over the cases that have sadly gone rather wrong and it's is quite a heavy blunt instrument really…it's not so much supportive and learning. I mean, you know, obviously we're not talking about a really negligent thing, some things are negligent in which case they have to be dealt with, obviously, appropriately, but there is a fear now that I don't think there was before.'
> Karen, London

This health visitor went on to say that in such cases there was an incentive for health visitors to close their eyes to need, as this minimised the risk of failing to successfully deal with it. A team leader said:

> 'I think there's also a worry that if you miss something and a child… something happens to a child, and you can't justify why you haven't gone back, then you're in big trouble aren't you? …they'll say, 'Oh well, if you picked up a need you should have gone back'. I think it's fear, and it's professional judgment at the end of the day, isn't it?'
> Ruth, North West

Several interviewees said that the areas in which they worked had high infant death rates, mainly due to non-accidental injury, which increased the sense of responsibility that health visitors felt. Where staff were presented with the conundrum of needing to reduce visits but also to carry out child protection to the highest level, this put the individual health visitor in a difficult situation. Many chose to continue working in ways they considered safer, in order to protect themselves as well as their clients:

> 'Sometimes I have to tell myself…you have to learn to say no, but because my caseload is very high child protection, I feel very strongly that I have no intention of ever having my name in the paper….I've been a nurse since 1970, and I'm not losing my registration now because somebody says that I can't do visits.'
> Barbara, South East

These issues of practitioner autonomy and managerial control will be discussed in more detail in the next chapter, which deals with the reform of the CHPP in the context of more generalised organisational change.

5.4 Conclusion

This chapter has been concerned with the two themes of meeting the health needs of children and families and the functions of the CHPP. It is apparent that the CHPP forms the framework for making contact with families, and is valued by health visitors as a legitimate and accepted way of doing this. Contact with families permits the identification of health needs. Interviewees saw themselves as being able to work effectively with families to improve the

environment in which children lived, but sometimes the number and range of health needs identified outstripped the capacity of local health visiting services to deliver. Targeting was seen as problematic due to the risk of missing children's health needs, and the requirement to match the identification of children's needs with what could feasibly be provided to meet them. When demand was too great, targeting for child health promotion services could be limited solely to children at risk of harm.

Chapter 6

Interview findings II: organisational change and the use of resources

This chapter is concerned with the themes of the availability of resources and organisational change. These themes emerged as being of major concern to health visitors, both from free text comments added to the survey, and from the interview findings. They reflect the institutional context in which the move to a predominately targeted service, has occurred. Both organisational change and the allocation of resources have contributed in complex and often hidden ways towards the increasing targeting of health visiting, as an accompaniment to the reduced universal child health promotion programme. I will start by giving a brief overview of resources for local health visiting services and then move on to looking at CHPP reforms within the wider context of organisational change in other aspects of health visiting provision.

6.1 Resources

Interviewees presented a grim picture of the resources available to mainstream health visiting services. The main cause of this was PCTs being in financial difficulties, which led to savings been made by reductions in numbers of staff and frequent job freezes. London and the South East appeared to be the worst hit, but interviewees from all regions described their PCT as having serious money problems:

> 'We have got a freeze on all vacancies, and our PCT it was split…about five years ago…but they have re-joined now…All the money or the lack of money is a bit chaotic; they literally re-joined a couple of months ago, so funding is all up the creek really.'
> Jess, Midlands

All PCTs were described as trying to save money by reducing staffing costs. Ways of doing this included not replacing staff who left, not replacing dropped hours, not covering maternity leave and sickness, and job freezes.

Any unfilled post was examined by a panel rather than automatically filled, and was frequently lost in the process:

> 'If you manage without somebody then they kind of disappear, that post is gone, so at one time there was bank employed and now…that doesn't happen anymore.'
> Karen, London

The result of this management strategy towards reducing staffing costs was that many health visitors were working with what they described as impossibly high caseloads. Caseloads which had previously been staffed by several health visitors were now covered by much reduced numbers. In the worst case, a caseload of 2500 was now run by two health visitors and two part-time health care assistants, where there had previously been 6.4 whole time equivalent (WTE) health visitors.[44] In most Trusts some health visitor posts had been filled with other grades of nursing and non-nursing staff, such as staff nurses and nursery nurses. However, these posts were also subject to job freezes and often not covered for sickness or maternity leaves, so the picture remained of a team reduced in numbers as well as skills.

All interviewees were aware that the picture across the country was of an under resourced and struggling service, though little oases of better resources were to be found in Sure Starts and other areas with outside funding. As a consequence some health visitors adopted a comparative perspective on their work load, and were satisfied with being able to provide a reasonable, if compromised, service:

> 'We have found with all the NHS cuts recently that we've had a job freeze on in the area, so as people are leaving or hours are being dropped by people going part-time…we're not getting them replaced so what we'll be able to offer seems to be gradually decreasing at the moment….It's not as bad as some areas. I did go to the CPHVA[45] conference and from what I heard there, there are some areas that were way worse than what we were.'
> Jane, Midlands

[44] Out of the 25 interviewees one fifth had caseloads of 500 or more per WTE health visitor, putting them in the top 10% highest health visitor caseloads in England (Gimson (2007).
[45] Community Practitioners and Health Visitors association; the main health visiting union.

> ‘I think we are terribly lucky, in that I don’t think that we’ve got an unmanageable caseload.’
> Kate, South West

Health visitors were not only working in an environment where the PCTs were struggling financially, but where other public services were also depleted. More than one interviewee spoke of the local social services being under special measures, and in many places social workers were described as only being able to take on the most severe cases. Elsewhere the speech and language therapy service was described as collapsing, midwives were overworked and had little time for health promotion, and school nurses were stressed and leaving in large numbers. Voluntary agencies such as Home Start had insufficient numbers of volunteers, leaving a large hole in provision for post-natal depression. Whereas in the past Sure Starts had supported health visiting by financing extra posts or hours, often this extra funding had now stopped. Children’s Centres were described as being less well funded, and having to charge for some activities, which meant they were not affordable for the poorest clients. All these factors contributed to health visitors having fewer other agencies to refer clients to, and meant that they were left with responsibility for clients for whom other services were not available.

6.1.1 Which health visiting services are cut?

In some areas there were suggestions that the whole of the health visiting service was under threat. Where Trusts had reconfigured, some interviewees said that their contracts were due to be revised within the next year, and they were concerned that they would not automatically keep their posts. Two interviewees spoke of threats of redundancy, usually conditional on the service being radically reformed. One interviewee, working in an area of previous ‘disinvestment’ in health visiting (that is drastic enforced saving on staffing and organisation costs), feared that this would happen again. A London health visitor said jobs had been under threat, but a survey of local

service users carried out by the PCT showed that health visitors were appreciated by over 90% of their clients, which earned them a reprieve.

Most interviewees described service cuts. The major areas in which cutbacks had been made are discussed below.

6.1.1.1 The core programme

Some interviewees described a process by which the core programme was regularly reduced according to the resources available:

> 'Our core programme originally was developed through Hall, 2004, and as the more and more the cutbacks came, the smaller and smaller and smaller our core programme's got.'
> Barbara, South East

Where there were insufficient numbers of staff, it was necessary to reduce the programme to a level which could be achieved by remaining staff. This could mean well baby clinics being excluded from the programme, and therefore no longer needing to be provided, or screening for post-natal depression being discontinued. In some Trusts there was a process of consulting with staff about which elements of the programme would be reduced. This interviewee felt that reducing the service further was tantamount to ceasing to provide health visiting:

> 'What we're going to do tomorrow is talk about what we can shed, and if we shed any more we might as well come home and just do knitting really. I do feel that they're just trying to disband the service, although they say they're not.'
> Theresa, London

Not only did the CHPP shrink, but it was often impossible to provide the minimal level of service laid down. One Trust had institutionalised not being able to provide the core programme into practice: when the Trust was on 'red alert' only child protection and new birth visits and clinics were to be undertaken. At the time of the interview this health visiting team had been on 'red alert' for 6 months, as had two neighbouring health visitor teams, and the

interviewee doubted whether they were actually achieving even this minimum level of service. Many interviewees said that given the option of providing a 'minimum core programme' (NSF for Children, DH 2004a), PCTs, unsurprisingly in view of their cash shortages, opted to provide the minimum. Most health visitors described the core programme as prioritised by managers, but difficult to deliver due to the increased amount of work health visitors were covering. Where the core programme had been formalised into a service specification, not meeting the basic CHPP in operation meant that health visitors were not delivering the service commissioned by the PCT or other commissioning agency. Several health visitors felt that they were not given the resources to provide the service that was asked for by management:

> 'I don't think we've been given really the resources to achieve that actually, but I don't think it's been recognised by management.'
> Frances, South West

6.1.1.2 Health promotion and prevention

Reducing the core programme meant that it was difficult to find time to do health promotion. In this situation the screening aspect or assessment was prioritised without any additional health promotion being offered:

> 'I think again staffing levels play a huge part to the effectiveness of it and sometimes we are just providing very basic screening, in a way, primary visits, but we can't follow up by providing health promotion.'
> Natalia, South West

Where the core programme could not be provided, health visitors were frequently told by managers to stop group health promotion activities. These included baby massage groups, weaning sessions, post-natal groups and groups for teenage mothers. Health visitors were acutely aware of the irony of being instructed to stop health promotion activities targeted at exactly the groups and health needs defined as high priority by the government. A health

visitor in the North West was told to stop providing a successful and well-attended weaning group to her inner-city Asian clients, despite known poor weaning practices among this group and high childhood obesity.

As well as group activities, public health activities for a wider population were also under threat. One interviewee was advised by her manager to reduce her workload by stopping weekly visits to the local refuge. She found this unacceptable because of the importance of this work in meeting the health needs of the local population. Child protection issues were high among the families in the refuge, and there had recently been an infant death, to which parental neglect had contributed:

> 'We are not allowed to do any extra, I mean, I've kept the refuge on by the skin of my teeth but I'd have had that pulled out from beneath me, but I fought for that …they were basically saying, 'Well, we haven't got enough hours in the day for you to offer them that sort of service'- which is not by any means an adequate service- …[the manager said] you just have to tell the people who run the refuge to get them to register and come up to clinic.'
> Naomi, South East

Many health visitors saw themselves as no longer being able to carry out preventive work, because all they could do was 'fire fight', generally in clinic situations. Instead of doing preventive work health visitors described themselves as dealing with an increased number of crisis situations, 'picking up the pieces' after major trauma within families.

Some managers were keen for staff to engage in health promotion activities, but without the resources being available to make this possible:

> 'I think what they would like us to do is have a lot more courses, so be running smoking cessation courses, perhaps healthy eating courses, but the actual organisation for those sorts of activities isn't really available. We're so depleted staff-wise that… it's a bit disingenuous, I think, of the management.'
> Vanessa, Midlands

6.1.1.3 Home visiting

Many activities which had been previously carried out on a one-to-one basis, often at home, were now provided in groups. This included developmental reviews at one year and two years, often presented in the form of birthday parties. Some appreciated that this had to be done, as it was a more economical use of time, especially where children did not have high priority health needs, but group checks happened even in areas of disadvantage. Many interviewees felt that group sessions were unsuccessful because parents preferred to be seen individually and did not attend; therefore children were not seen at key CHPP points. One gave a graphic description of the difficulties of attempting to carry out a group health promotion session for six parents and their two year old children in a room not suited to the occasion.

About half of the interviewees said that their managers wished them to do only minimal home visiting, and to invite clients to clinic as far as possible. One area was trialling new birth visits being carried out at clinic, in order to maximise the number of clients that could be seen by health visitors in the time available. Elsewhere the veto on follow up home visits was so strict, that a health visitor had been prevented from visiting a premature baby at home. After informing the health visitor that she must stop visiting at home, the manager went to see the baby's mother to tell her she must come to clinic. The restriction on home visiting was described as putting enormous stress upon health visitors to identify health needs, as clinics did not provide enough privacy to allow clients to discuss potentially serious problems. In some cases, when combined with other reforms such as a corporate caseload, or health visitors working geographically, this could make it difficult to get to know clients:

> 'Most of the work we do is community clinics so we don't necessarily see the same people each time … it is quite disorientating in as much as you don't develop a clientele in the same way… we get quite a lot of clients flowing around the whole of

> the borough so…I'll do a new birth and I will probably never ever see that family again. The majority of them I will never see again.'
> Karen, London

Where teams' follow up visits were delegated to community nursery nurses (CNNs) or other team members, this meant that clients were less likely to see the same person for more than one home visit, and again reduced the likelihood of health needs being brought to light and addressed. Where clients were not well known to health visitors this led to difficulties in monitoring children's well being. A health visitor here describes her attempts to follow up a child's missed speech and language therapy appointment:

> Probably in the past you would have known them, you see, so you'd have gone, 'Oh, why isn't Aimee going? Let's see what's happening with her'. Whereas now it's, 'Oh well, I don't know who this Aimee is, nobody knows who she is'… you're kind of just dealing with little bits that you don't know enough about.'
> Karen, London

Despite other agencies, often still expecting every child to be known to a health visitor, this was no longer true in many areas, meaning that informal monitoring could not take place. When health visitors tried to follow up missed appointments, outside the context of an established relationship with the parents, it was likely that parents would avoid contact.

6.1.1.4 Health visiting infrastructure

Not only were numbers of health visitors cut and the services which they provided, but also the environment in which they worked and the facilities they had available to them had deteriorated. This could range from stationery not being available, lack of computers or incompatible systems, teams being split across bases because of lack of space, and clerical support posts being cut.

The most common erosion of the health visiting infrastructure was in losing suitable premises in which health visitors could be based. Many health visitors had moved out of GP surgeries following the introduction of the new

GP contract. Interviewees reported that finding suitable alternative accommodation for health visiting teams was problematic, and in some cases health visitors were working from ill-equipped buildings, situated a long way from clients. One team had been moved to premises shared with another team, which were too small, too far from the clients to allow them to drop in, and which was without desks or computers for several months. In another instance a decision not to employ receptionists led to clients having difficulties in making contact with the health visiting team:

> 'We have noticed a decline in the number of people contacting us, part of that is because they have cut the reception, so we have no reception staff, so all the phones are routed through another base which is very busy and the phone is constantly engaged so people can't get through….They cut back, because when the reception staff left they didn't replace them because of the money, so no reception.'
> Hannah, South East

This has a particularly eerie resonance, because it parallels an example given by Lipsky (1980) of the ways in which services are deprived of resources, leading to service providers, against their wishes, becoming incapable of providing a service which clients find useful.

The infrastructure of health visiting was also being eroded by the lack of training available for new health visitors. Previously the one year post-graduate health visitor training had been funded centrally by the Workforce Development Corporation, but recently responsibility for funding this training had passed to PCTs. Most interviewees described their local PCT as not currently funding health visitor training. The lack of students contributed to the feeling among interviewees that health visiting was being run down as a profession. The resultant reduction in community clinical tutor posts (to supervise and teach health visitors in training) also reduced the opportunity for career progression for experienced health visitors.

6.1.2 What are the effects of cutbacks on the service provided?

Cutbacks were the main reason for health visitors feeling they did not provide a good service. All interviewees considered a good service was one where there was enough contact with clients to be able to identify and address health needs. In the best cases, health visitors had time to spend time with mothers having breastfeeding difficulties, and even visit on a daily basis if this was deemed necessary. Normal developmental issues, such as children's behavioural problems could also be given time. Health visitors who considered they provided a good service were the Sure Start health visitors, a health visitor in an area where more staff had been allocated due to high health needs, and two health visitors in areas where decisive efforts had been made to revise the local service in line with national policy on prevention and health promotion.

The majority of interviewees considered they now provided a compromised service:

> 'We've recently, like all health visitors, I'm sure, you've spoken to…had quite a few cutbacks and things, which has been quite frustrating in a lot of ways because we're looking at health needs that we can't always implement things to actually deal with…because of the cutbacks on the hours and the time we've got with our caseloads. So it's been quite frustrating from that point of view.'
> Megan, South West

> 'The numbers have gone down haven't they? The numbers of whole time equivalents and yet, you know, asking us to take on more stuff…it just feels a bit thin, very thin really.'
> Diane, South West

> 'It's having the time to do the work properly, because I do find we all cut corners and it's unsafe to do that, and we get stressed… We aren't really providing a service, the service that is needed by the clients, and therefore the clients then - I don't know whether they fend for themselves or they just sink under. It depends really on them, I guess. But that's not good.'
> Maya, London

> 'You feel terrible because it is…not that we can't be bothered, it is just that there are only so many hours in a day and there is only so much that you can do… It sounds dire … it is dire… I'm having a week off this week, because I can't cope with the

pace any longer. I'm just having a break because, you know, you just can't continue along that line, in that vein… without making yourself ill.'
Naomi, South East

The most painful aspect of the cutbacks for most interviewees was feeling that the service that they provided did not meet clients' needs. However, in trying to meet these needs health visitors were left with a choice of driving themselves to work harder with fewer staff, or to become resigned to giving a poorer service.

6.1.3 How have health visitors responded to service cutbacks?

About a third of interviewees described having taken action to protest about cuts to the service. This was most commonly verbal protests at meetings, or letters to management, but also included contacting CPHVA, carrying out audits to show health visitors were being overstretched and needs not met, and writing to or meeting MPs. One union representative was about to use the Amicus code of conduct to put pressure on her Trust to reduce health visitor caseloads. Another interviewee had seized the opportunity to take part in the review of health visiting 'Facing the Future' and had taken part in a group discussion with a junior health minister. She appreciated the opportunity to make her views known at a high level, but did not feel that the minister took on board what was happening to health visiting:

Q 'What did the minister say when people talked about the cutbacks and the morale?'
A 'He was very evasive - you know what they're like - he just sort of didn't say that much really, and talked about all the good things that were happening in the NHS and how good it's all going to be, and how they're making the changes to make it better.'
Megan, South West

Rather than taking action, either on a national or local stage, most health visitors described themselves as attempting to continue to provide a good service to clients at an individual level. Many health visitors described working overtime in order to get through their work:

> ‘We will go out in our lunch hour, after work, whatever, out of hours, visiting the clients because the work has to be done; our managers say we should just prioritise.’
> Alison, Midlands

Several health visitors described very high sickness levels among colleagues, which then increased the pressure on those who remained. Even staff that had had time off work due to stress could not be protected when they came back to the job, because working demands remained so high. One London health visitor said that the Trust had reduced the staff to a minimum number, which resulted in more staff leaving because of stress levels. She considered that ‘only people who have to come to work’ now remained in post, a valid concern in a female, predominantly part-time workforce. Some interviewees described a widespread acceptance of overwork and high stress levels:

> ‘When I first started out, I was in a situation where I think my caseload was something horrific round about 500…When I pointed out to my line manager that it wasn't healthy for me and I'd go off sick or I'd end up being admitted…she said, ‘Oh Prozac's good, I'll come and visit’, that was her comment, and I was left as a newly qualified health visitor minding three caseloads, and told to more or less get on with it.’
> Beverley, North West

Many health visitors said they feared that due to working in a rushed and pressurized way that they would make mistakes. Health visitors described being forced into a way of working which they did not feel met the needs of clients, and which left them open to criticism if anything went seriously wrong. Overwhelming demands combined with a lack of ability to meet the needs within the level of service provided, contributed to enormous stress being experienced by some health visitors.

> ‘Well, if I use the word burn out it will be too harsh….there's much pressure, we are stretched…because of the overload you know, of work, and writing, things like that, litigation…at the end of the day there's too much pressure because of overwork.’
> Olanna, London

6.1.4 Which services are not cut?

Not all health visitors were working under the financial and organisational difficulties as described above. About a quarter of interviewees described themselves as being able to provide a reasonable or adequate service. Those who could provide such a service were generally working in areas where staff numbers had been increased in the areas of highest need, or were working for Sure Start or with additional outside funding. Funding from outside sources often enabled health visitors to provide the sort of service they wished to provide. Two interviewees described themselves as having almost an embarrassment of riches:

> 'I'm working where I like to work…if somebody said to me a few years ago you can be in an environment with a multi-disciplinary team…I work with about twenty four people, family support, early years, a midwife you know, so there's lots of different groupings and… it's a nice building…so we've got, you know, fabulous facilities and I can spend my time thinking about social public health, breastfeeding, infant massage and…working directly with families, well…that's my kind of job really.'
> Paula, South East

> 'Where I am based…is the flagship of the community… it was…successful in its New Deal bid and got about fifty million quid for a complete regeneration across the board…[there] is a Health Living Centre …it incorporates the primary health care team, but that is only a small part of what goes on.. There is a big arts project that runs all sorts of classes, as well as a community arts thing…there is a big wellbeing project and that is running things in response to people's demands, like yoga and baby yoga, and all sorts of things. There's men's workers, a complementary health project, there is a crèche, there's drugs workers that come in, there's the local alcohol and advice people, there is counselling, there is race equality, there's youth workers, there's somebody from the public health department. Fantastic.'
> Kate, South West

Not only did these health visitors have resources to offer clients, but they benefited from working in places with good morale, in a supportive team and where they did not appear to be struggling to provide a service at an almost personal cost. Health visitors working for Sure Start generally spent their time providing services for groups of clients, rather than having a caseload, and did little child protection work. There was some joint working between the mainstream and Sure Start services. A few mainstream health visitors carried

out their CHPP developmental checks in the Sure Start building to try to attract clients to use the facilities, and Sure Start health visitors carried out CHPP activities for health visitors on clients they saw regularly. One Sure Start health visitor was loaned out to the trust on a weekly basis by her Sure Start manager to shore up the mainstream service:

> 'I did have a caseload initially for one or two days a week to help the health visitors who were desperately short of staff, so I did some of their work for a year or more…my manager was kind of the impression that how can you possibly start providing add-on services, when you can't even provide the universal service.'
> Chris, South West

6.2 Organisational change

In order to understand the issues discussed above it is necessary to look more widely at organisational change within the NHS, and the reasons why health visiting had been subject to such radical changes. In this section I will discuss the changes that have happened in employing organisations which have affected the way the CHPP has been developed, practised and modified. CHPP practice is affected by national and local policy on health promotion for children, but is also affected by other national and local practices which affect the environment in which health visitors work, and their interprofessional relationships with other service providers. What was increasingly shown in interviews was that other policy initiatives have affected the CHPP as much as the sequence of Hall reports which initiated widespread change. In place of a direct and linear influence upon the CHPP, it became obvious that other policies, working together (sometimes against each other), have had a profound effect.

Interviewees mentioned a variety of policies which had an effect upon the way they worked with pre-school children. These included 'Every Child Matters', 'Choosing Health', 'Safeguarding Children', the Modernisation Agenda, the New Deal, LIFT and NICE guidelines. I shall discuss the policies

which have most affected the way in which health visitors provide the CHPP below, beginning with the ones which appear to have had the most direct effect, and progressing to those which have affected preventive health services less directly, but no less significantly.

6.2.1 The modernisation agenda

Two aspects of the modernisation agenda have had a large effect upon health visitors' practice: corporate working and skill mix. Corporate working involves a team of health visitors covering a caseload, rather than each health visitor having an individual caseload. Some health visitors preferred this way of working because it spread responsibility amongst the team and could therefore reduce stress. Most agreed that it was attractive to Trusts because it eked out a smaller numbers of health visitors over larger numbers of clients. Corporate caseloads could be used to 'hide' vacancies':

> 'It's just a corporate caseload so we're not allowed to have vacancies.'
> Ruth, North West

Several interviewees claimed corporate caseloads had been used to increase their workload, especially where jobs were frozen or colleagues off sick. In one Trust, corporate working has been criticised in a part eight Child Protection Review, because it was not obvious which health visitor had responsibility for the child. Another Trust had tried corporate caseloads but returned to individual caseloads, because clients preferred to have a named health visitor, and access to the 'hard to reach' had fallen. A number of interviewees had resisted the move to corporacy but had been unable to resist wholesale change within the PCT. In several areas GPs had resisted corporacy, and in two cases health visitors had been instructed not to inform GPs until the change had been made.

All but one interviewee worked in a 'skill mixed' team, which included community nursery nurses (CNNs), staff nurses or health care assistants. In Sure Start areas the team often included a variety of early years and family support workers, and also other health professionals, such as midwives. Frequently non-health visitor members of the team were described as having higher qualifications than required for the role, such as being a non-practising midwife, or having an academic or professional qualification, which contributed to their ability to work well with clients. Some teams had been able to recruit staff nurses with either a mental health or paediatric qualification, which greatly enriched the team and increased their capability to meet local health needs. All the Sure Start health visitors made the point that sometimes other members of the team had better abilities in performing some aspects of the health visitor's role than health visitors themselves.

A minority of interviewees were vehemently opposed to skill mix, with the majority cautiously favourable. Most health visitors pointed out that they had no objection to skill mix *per se*, but did object when it was accompanied by reductions in numbers of health visitors. Problems arose when team members had insufficient skills and experience to deal with difficult problems that emerged during the course of a routine contact, such as domestic violence and mental health problems. Health visitors spoke of the difficulty of anticipating visits which would be suitable for a CNN, given the unpredictability and wide range of health visiting work. This was particularly worrying for health visitors in areas where it was suggested that CNNs should carry out primary visits to new babies. One interviewee described a recent home visit, which on paper looked ideal for a CNN, but at which she had found that the baby had a tongue tie, the mother was suffering from stress incontinence and the older sibling had undiagnosed eczema. The interviewee doubted whether a CNN would have the clinical assessment or communication skills to identify these problems and refer appropriately.

Worries were expressed by interviewees that in the new commissioning structure there would be increased pressure on managers of the health visiting service to use less highly qualified staff as a cost-cutting measure. Almost all interviewees saw the introduction of skill mix primarily as a cost-cutting measure, and as a means of rationing the health visiting service.

6.2.2 Modifying the health visitor's role

Several interviewees described commissioners, both PCT and GP, asking health visitors to take on additional roles. Examples of this were: providing a child protection service to school age children where there were low numbers of school nurses (in two areas), providing triage in Accident and Emergency (A&E) Departments (in two areas), flu immunisations for the housebound, elderly visiting (in two areas), and running contraceptive clinics. Sometimes health visitors welcomed these added roles, which widened the scope of their work, but some felt they were not adequately skilled to carry out these tasks, and that dilution of their role left less time for their work with pre-school children. In order to accommodate the extra work health visitors were told to 'prioritise', which meant adjusting the level of the service for children and families by raising thresholds for targeting. Many health visitors objected to being almost arbitrarily summoned to meet other targets, when they felt they had pressing responsibilities in their own area of work:

> 'When a new project comes to light or whatever, it's a little bit like go and get the health visitors to do it. But it's like we can do anything and everything, fit in with everybody's package.'
> Barbara, South East

> 'The challenge we're having now is that everybody thinks health visitor is out there to help them run their business, and I think that's…not all right, because I think everybody should go out to do their role, we've got our own role. We have more than enough on our hands.'
> Olanna, London

Setting up a triage system at A&E was intended to reduce the costs of paediatric admissions to hospital, a target set for PCTs by government. One interviewee described how local health visitors were forced to do this role despite opposition. She particularly objected to health visitors being inappropriately used as a buffer between the PCT and hospital doctors:

> 'We were actually threatened with redundancy at one point, we were told you came this close- it must have been one of the managers- this close to being made redundant …what they are saying is that if we don't go and work in A&E you will not survive as a service, if you don't do what we want you to do, you will not survive… the thing is, if patients are being admitted unnecessarily to the hospital, then it is an issue for the commissioner to take up with the hospital, not to send in us to go and challenge the doctor's diagnosis.'
> Hannah, South East

Where health visitors felt that their jobs were at risk, it was difficult for them to refuse to take on extra work, even when they considered it outside their area of expertise or an invalid exercise.

6.2.3 Agenda for Change

Pay scales for NHS clinical posts, other than those for doctors and dentists, had been revised under Agenda for Change (AfC) about a year before the interviews took place. Many interviewees brought up the AfC grading exercise, as having had an effect upon health visitors' morale, and upon health visitors' status within the NHS. Generally health visitors were not dissatisfied with their pay, but they felt that their skills and experience had been insufficiently recognised in the grading exercise. Whereas previously health visitors had been on the same grade as a ward manager or hospital sister, senior clinical hospital nurses and midwives were now graded more highly than health visitors under AfC. For interviewees who had come into health visiting as a sideways move from a senior clinical nursing post, this signalled that they had made the wrong move in career terms. Interviewees felt insufficient recognition was given to the complexity of their work within the home, and their high levels of responsibility, particularly their child

protection caseloads. Interviewees felt that career development had been reduced and that health visiting had become a dead-end post with little prospect of career advancement. Some interviewees felt that specialist health visitor posts, such as health promotion specialists, carried less responsibility than routine health visiting and did not merit higher pay:

> 'A lot of nice little specialist jobs [are] coming up on band 7 and I don't understand why they're being paid more for taking lots less responsibility, not getting cold, wet or dirty, and always having an office next to a toilet, hot and cold running and an easy cup of tea, and always somebody to go back and tell their troubles to… When I was off sick… I had to hand over some files [to] one of those newly appointed specialists…she said, 'I don't think it's fair, that makes eight'. Eight? I've got sixteen in blue, five in red, umpteen others in green, yellow, all the colours of the rainbow, plus another five hundred and something. She doesn't think it's fair because she's got eight? And she's not going to visit them. It beggars belief actually…she gets paid more than I do [and] she takes none of the risks that I have to take.'
> Theresa, London

Feelings ran particularly high when specialist posts were in area of health visiting (e.g. sleep or behaviour management) which were traditionally part of health visitors' routine work but which they no longer had time to do. One trust had graded their health visitors at a higher grade than the national average, and this was reflected in increased job satisfaction.

In addition to pay, AfC created a situation in which it was possible to limit the work that health visitors do. As part of AfC a job description had to be developed within each PCT. Many stated that this job description contained the bare minimum for the role and did not include many of the wider aspects of health visiting. In practice most health visitors had an area of particular interest or expertise, such as breastfeeding, special needs children or immunisation, but this was not reflected in the job description or the subsequent grading. Interviewees considered that because the health visitor role was undervalued in the AfC job description, what health visitors had to do within Trusts was generally set at a very low level. In a Trust where health visitors had been given a higher grading, a dynamic union representative had

proposed a job description which included all the specialist activities being carried out by health visitors within the Trust.

6.2.4 The purchaser/provider split

A change which was about to happen in many PCTs, and which had already happened in some, was the PCTs ceasing to be both provider and purchaser of community nursing services. Where commissioning of services by another agency was looming, there was pressure to be clear about what service health visitors provided, and to define the core programme. In a number of areas health visitors said that the CHPP had become the measurable framework of what the health visiting service offered:

> 'They're setting up commissioning units…and we've got to prove what we're doing and you've got to prove that we're effective, and nobody's going to buy our services if we don't do that, and it's easier to do something that's measurable, isn't it?
> Ruth, North West

Health visitors were often uncertain about who would commission their service. The specialist health visitor for gypsies and travellers had severe doubts whether any agency would consider commissioning her service:

> Q 'How are you going to be affected by commissioning? Who will commission your service?'
> A 'Well nobody will, will they? ... That's the whole point, nobody will want to commission our service because it's not an attractive service, it's just the opposite. So we're going to have a real problem.'
> Q 'And why do you think you're an unattractive service for anybody to commission?'
> A 'Well, because it's a client group that people don't have fond feelings for. It's a very needy client group…it's a labour intensive client group. You know, they're not good at meeting their targets, so they're not going to come for their jabs, so you can't say, well okay, we'll tick all our boxes, because it won't happen. A lot of work, you know, it's a huge manpower workload really.'
> Alison, Midlands

In this case 'ticking boxes' meant meeting GP targets. While health visitors were described as following a public health agenda, GPs were seen as concerned with caring for just their own patients. Many interviewees were

concerned that none of the services they provided were linked to GP targets and hence payments, giving no incentive to GPs to take on the service.

> 'The whole idea of commissioning is very interesting because nothing that I am involved in, even to do with the public health, earns the GP any money. And then you have to consider whether from...a business point of view for a doctor, you know, what's in it for them really? So yes, I think that's a huge difficulty with the, you know, the commissioning structure.'
> Paula, South East

One interviewee anticipated being employed by United Health Care (an American multinational) within the next few years, but most thought that GPs would be the commissioners of health visiting services, with perhaps public health services being provided out of Children's Centres. Interviewees were unclear about how commissioning would be shared between the local authority and GPs, and expressed concerns that there were, as yet, no signs of dialogue and liaison between GP commissioners and local authority commissioners.

In a minority of areas GP commissioning had already been introduced. This appeared to work well where managers could clearly demonstrate that aspects of health visiting met GPs' targets, and these were taken on by GPs. Services which GPs were generally happy to commission from health visitors were immunisation and smoking cessation. However one health visitor reported that her team were no longer able to provide immunisations plus health promotion at key CHPP points because the GPs preferred to employ a practice nurse than pay for a more expensive health visitor to immunise. As a consequence immunisation rates were dropping, and the health visiting team regretted the loss of a useful and well-liked contact. Here the ideal (and rarely encountered) situation as laid down in the NSF for Children (DH 2004a), of health promotion being given at the immunisation contacts had been abandoned, when the service had to be paid for by GPs rather than the PCT. This interviewee also reported that health visitors had been

discouraged by GPs from referring to a PCT specialist paediatric dermatology nurse because this would incur costs to the practice.

6.2.5 The new GP contract

Because of the incentives to GPs to maximise the services offered from their surgeries, many interviewees described GPs ceasing to allow the PCT to house health visiting teams in GP surgeries. Services such as additional clinical nursing services were offered, meaning that health visitors had to be removed to other accommodation:

> 'We've been kicked out of the GP surgery…since…the GP contract they get more money for doing all sorts of different extra clinics, so our practice have now taken on a nurse practitioner, so they had to bump the health care assistant who does the blood out of her room, so she's got bumped into the health visitors' room…we weren't paying that much rent anyway…and also the GPs felt that we weren't necessarily just working for their patients anymore because we were now doing the geographic thing.'
> Diane, South West

Some GPs regretted the loss of the close working relationship with health visitors:

> 'I think an awful lot of communication is required to keep the GPs on side and happy…they're currently very unhappy that they've lost the girls that they used to know…it was their fault because they kicked her out of the surgery….they wanted space when they started increasing the amount of work the practice nurses did.'
> Jenny, North East

Moving from GP surgeries had an effect upon communication with both the GP team and the wider health service. Where health visitors were relating to a number of practices they were no longer known within the practice, and this made information sharing, for instance with receptionists and practice nurses, much more difficult. Some interviewees also reported no longer receiving notification of children aged 0-5 years moving into the area since leaving their base at the GP surgery, and not being informed of babies leaving a hospital Special Care Baby Unit who needed to be seen by a health visitor.

Direct links were made between the increased remuneration available to GPs through the new GP contract and the lack of money available to health visitors. A team leader found the disparity between GP and health visitor funding acted to further lower morale:

> 'I think what really annoys people, is that we know that loads of the money problems are to do with the GP contract… I think people can see that most of the money seems to be heading through the doors of GP practices, and I think that creates quite a lot of ill feeling, so…you've got to do what you can to motivate people and say…within the constraints, within the fact we have no resources, this is what we can do.'
> Diane, South West

6.3 Preventive health services for children: joined up policy?

The third section of this chapter is concerned with health visitors' views about policy on health visitor-provided services for children both within the PCT and in the government. Most expressed the view that policy in the health service changes rapidly, with new initiatives appearing every few months, and that NHS workers have a hard task keeping abreast of policy changes. Some interviewees were reluctant to talk about policy in abstract, as distinct from talking about their work and their clients, because they did not feel that they knew enough about it, or that they were not the best people to pass an opinion. Notable exceptions to this were team leaders and union representatives. One representative said that keeping abreast with policy developments helped her to cope with change, as she then understood where change was coming from and what pressures were put on PCTs by central government.

In talking about their role, their clients and the nature of the work, interviewees were often concerned with how health visiting was perceived. While health visiting could have a high profile in policy and practice, many health visitors talked about the tendency of health visiting to lapse into

invisibility within the NHS. Although distinctions between being seen and unseen were often complex, this theme of invisibility has been used to shape the following discussion of healthy visitors' views on national and local policy.

6.3.1 Invisible clients

Clients were described as being highly visible in government policy, because of the emphasis on targeting services to the most disadvantaged. Some health visitors were cheered by policy which they saw as targeting exactly the sort of children and families they were working with. However, although health inequalities were presented as of high importance in government policy, interviewees did not see this as translating down to PCT level. The main reason for this was that despite giving high priority to the most socially excluded, funding was not made available at a local level to meet their needs. Because of PCTs' financial difficulties, decisions were made locally about which services to cut:

> 'On the one hand you have got the government coming out with glossy documents saying that we are interested in promoting health and improving health, and on the other hand you have got waiting lists and you've got cutbacks and the budgets … and when it comes to the crunch the government doesn't seem… to be able to implement these policies, the trusts do what they want, and they are being forced to balance the books and that is the number one priority. So the things that go down the pan are preventative, they are not interested.'
> Hannah, South East

Thus many felt that, despite avowed interest in these clients, neither government nor local managers were truly interested in meeting the health needs of the most excluded. The neediest clients were seen as so marginalised and lacking in power within society that their needs became lost. Schemes such as GPs being paid for meeting targets provided little incentive to engage with the socially excluded, who are unrewarding in terms of appointments kept, courses of immunisations completed and lifestyle changes made. Locally there was apathy about meeting health needs because they were perceived as too costly to address. Many health visitors

saw a dissonance between different strands of government policy, which meant that in practice policies served to negate each other.

Few interviewees believed that the aim of targeting the health visiting service to the most disadvantaged had resulted in a better and more extensive service for those who most needed it. Changes such as reduced universal visiting and a de-skilled health visiting team had made clients more invisible as their needs were less likely to be identified. Most areas could not provide a targeted service to all clients with high health needs, but had to prioritise among a population with high health needs. The clients who most used the health visiting service were seen as least likely to protest about its absence, because parents lacked the skills or agency to fight for the retention of services (or do not wish to be targeted), and pre-school children cannot ask for a service to meet their needs.

Interviewees gave many examples of health visitors performing a function of making children and their health needs more visible to professional scrutiny. A traditional role for health visitors within the NHS was to follow up children who had fallen off the radar of hospital services. Commonly, health visitors were asked to carry out a follow up visit to the home to assess the situation when a child had attended A&E and there were concerns that parents were not treating their child properly, either by failing to comply with medical care, or because there were suspicions of abuse. Similarly if a child failed to attend a speech and language therapy appointment, the hospital department could cross them off their lists without having further responsibility, but health visitors were asked to assess whether there was a need for a future appointment or whether parents were not appropriately prioritising their child's health needs.

This additional health visitor role rested on health visitors' ability to provide a link between the private world of the home and the public world of the

hospital. Often it involved health visitors in challenging parents about the standard of care they were giving their child. One interviewee described a visit she made to a sick baby, made expressly to tell the mother to take her child to hospital:

> '[The mother] wouldn't admit the child, the doctor wanted to admit him into hospital, she didn't turn up…The ward rang me and said, 'We've got a bed ready, he hasn't attended - can you go and look?'…I went round and said, 'Why am I more worried about your baby than you are? That is worrying,' and she took that really well - I'd be really upset if somebody said that to me …they jump up all these outreach people all of a sudden, yet they wouldn't do that, would they?'
> Siobhan, North East

The reference to 'jumped up outreach people' denotes family support workers or Children's Centre workers, who many interviewees felt had a more placatory approach to parents than health visitors, and were less likely to challenge parents about substandard care of children.

Perhaps the most extreme example of the way in which health visitors can prevent vulnerable children from becoming invisible, was given by the specialist health visitor for gypsies and travellers. She highlighted the importance of treating child protection referrals with the utmost caution and sensitivity, as a false move could result in the family going 'underground' and not returning to the site. Similarly, outbreaks of infectious disease on traveller sites required a joint approach from public health and the specialist health visiting team, to prevent scattering of the community:

> 'We often get involved in public health work, for example…if there's a meningitis scare, because what tends to happen with travellers is that they all up sticks and go, rather than sit tight and wait and see what the result is, and whether they need antibiotic cover …They'd either go or they'd all go to the hospital…saying that I've had contact…So there has to be a huge piece of work there, instant piece of work, around educating them on what it actually is, and what the consequences are, and why they need to stay put… sometimes we will go out and do mass immunisations….we've gone out with our public health director and we've actually done them on site…They respond much better if they know you well.'
> Alison, Midlands

At the simplest level, health visitors make visible children who are otherwise in the private world of their home, under the care of their parents. This task of entering the hinterland of invisibility is most apparent in the proactive visiting of children in homeless hostels, refuges, circuses, or traveller sites, who would not otherwise be the natural target of any health services.

Sometimes interviewees considered that their role of seeking out children's and families' health needs, and requesting services to meet them, added to their unpopularity within the PCT:

> 'We keep writing letters, endlessly writing letters, but we're known as the Witches of [name of base]…I'm quite serious. My manager used to call us that because we're always writing letters….Because…we actually feel that we're advocates for our client population and if we feel the need is not being met….then they're getting, you know, short shrift really, aren't they?
> Frances, South West

6.3.2 Invisible workers

A handful of health visitors, who generally worked in more favourably financed and democratically reorganised areas, thought that health visitors were powerful people who could influence PCT policy at a local level:

> 'I think we're very vocal and I think we fight quite hard on clients' behalf. And I've often found over the years that we may be the only ones that are acting in the true advocacy role for patients in a very noisy way. And I think we influence policy quite well as well, which I don't think a lot of other nurses do.'
> Jeanette, Midlands

Many interviewees commented that health visitors were more politically aware and radical than other nurses and that the type of person attracted to health visiting was generally articulate and prepared to fight their clients' corner despite opposition. Health visitors' professional status afforded them some protection in being able to resist unpopular changes forced on them by the PCT, as did clinical governance procedures which had been used to prevent non-health visitors carrying out primary visits. More than one

interviewee used an army metaphor, saying that health visitors were 'foot soldiers' but with greater power to disobey orders. One health visitor said that her health visiting team would have been 'court-martialled' for their open resistance to changes in practice if they had been in the army.

While it was considered that health visitors had great scope to practise as they chose within their caseload, few interviewees thought that health visitors had much influence on national policy:

> 'The government policy, that keeps on changing and you just have to move along with any change that come, without them involving you, without asking you for your own knowledge and …they change it again and you have to work along. It causes another kind of problem for people…they just bring the result to you and say this is what you have to do, and you have to dance to their tune.'
> Olanna, London

Health visitors could be overlooked for a number of reasons. Firstly, as nurses they had low status within the NHS. Many health visitors strongly resisted losing their 'GP attachment' because they feared they would be even more vulnerable if not, at least nominally, part of the Primary Health Care Team. GPs were seen as valued and powerful health service workers, but not generally supportive of, or knowledgeable about, health visiting. Health visitors saw themselves as having few allies or champions. Despite health visitors' protestations that they are engaged in important public health work, only two interviewees described constructive liaison and joint working with their public health departments. The remainder had no contact with public health departments whatsoever. Managers, who were often not themselves health visitors, were seen as either powerless to resist changes, or themselves unconvinced of the worth of health visiting. Where PCTs had been reorganised some managers were in the position of reapplying for their own jobs, and therefore in too precarious a position themselves to oppose financially motivated reforms of health visiting.

Many health visitors saw themselves as being poor at fighting for their service. Few attended union meetings, often because of being too busy but also because many interviewees appeared to see themselves as helpless bystanders to an inevitable erosion of health visiting. Health visitors who did protest described it as a lonely battle. A union representative said:

> 'They won't come forward with their complaints, they just put up with it. They are completely ground down. The fear of losing their jobs that is what it is…[the] professional lead at the CPHVA said about fighting a campaign, but the problem is that it will be me fighting the campaign, because even one of the other union reps… doesn't really agree.'
> Hannah, South East

Feelings were mixed about whether the main health visiting union (CPHVA) had been effective in protesting about cuts. One interviewee said major job losses in her trust had been averted by a CPHVA campaign. The majority feeling was that while the CPHVA fought hard for health visiting at a government level, it lacked clout in comparison with unions representing more powerful groups. Some health visitors identified a lack of leadership in the higher reaches of health visiting, which had led to the current vulnerability of the service. Because of health visitors' invisibility, cuts could be made to the workforce without widespread notice or attention being given to what was happening:

> 'It's obviously saved a huge amount of money by cutting health visiting, health visitor numbers, and it doesn't really show at all.'
> Maya, London

The majority of interviewees thought that the biggest challenge facing health visiting was to survive as a profession. The lack of practical support by government for the profession, combined with the demographics of the current workforce, had created a situation where health visiting might disappear, almost of its own accord:

> 'I see that in this hard hitting environment, you know, economic environment…we're dispensable with…Although the Government are saying health visiting, they're

> promoting it in one way, but on the other hand we're not training anybody and we're all retiring…I can't see anyone else as, in some ways, as important, essential, to a lot of children's lives, and I think yet we go unnoticed perhaps, but that doesn't mean that what we do isn't really valuable.'
> Karen, London

6.3.3 Invisible work

Government policy seemed to fit in well with what health visitors do to support families with high health needs, and justified a lot of health visitors' work:

> 'When you look at the elements of the national framework with that, what is it called, 'Every Child Matters'. If you look at that, there are five elements there…and if you look at all the five….we are doing it.'
> Olanna, London

Where morale about health visiting was high this was often where interviewees described local health managers as having linked health visiting outcomes to local policy targets. Sure Start health visitors were used to tying in any work that they did with national and local policy, in order to demonstrate thereby that their work was worthwhile. This method of justifying work was well accepted within the Early Years environment, but had not been widely adopted in mainstream health visiting.

Most interviewees did not believe that the government recognised that important target-driven work was being done by health visitors. It seemed to them that issues such as parenting, or family support were discussed without health visitors even being mentioned. Many health visitors were incensed that when high prominence issues, such as children's behaviour, were the subject of media debate, their daily bread-and-butter work with families was rarely, if ever, mentioned. It appeared to them that government failed to recognise the service that health visitors were providing:

> ‘I have to say I was a little bit… very cross, when I heard Tony Blair talking on the radio, saying how important it was that parenting support started before they went into school and more assistance was to be put into place to stop ASBOs and bad behaviour, and, I hate to say, I was shouting at the radio in my car, saying, ‘You stupid man, what do you think I spend all my days doing?’… I don't think it's just him…I think a lot of people don't understand what health visitors do.’
> Barbara, Midlands

Interviewees saw their work as playing a large part in contributing to social capital in poor neighbourhoods, having wide consequences beyond the early years. Social ills upon which interviewees considered that early health visiting interventions could have an effect included childhood obesity, maternal and child mental health problems, substance misuse, family breakdown, social exclusion and youth offending.

Despite the focus on early years and improving the circumstances of children, interviewees did not believe that the government saw them as key players in the Early Years arena. The lack of recognition of the health visitors’ work was demonstrated by the fact that funding was directed towards other agencies, such as education, Children’s Centres and Sure Start, while health visiting was run down:

> ‘The emphasis has shifted elsewhere because the education provision is generous, enormous…Every child is in nursery by the age of three and they have Sure Start, which gets a lot of funds …that’s where the recognition and the finance is going.’
> Maya, London

> ‘Sure Start’s very much about group work and…it’s lovely to have that in your area and to have that resource, you know, they’re beautiful centres, well-resourced, and it’s nice to have that to offer people...a lot of money’s been put into it [but] you can only feel a bit resentful when…jobs are being frozen and you value the work that you do as well.’
> Sam, North West

Generous funding of Sure Starts seemed particularly galling when clients failed to use the services. Most interviewees, even those employed by Sure Starts, believed that the mainstream health visiting service enjoyed better access to clients.

Interviewees described themselves as being constantly faced with ignorance about what exactly their work was and how it was done. The Department of Health, clients, GPs, public health departments, PCT managers and commissioners were all described as being in the dark about what health visitors do. Interviewees said they were continually asked to define their work, even by their own managers. Some took a brisk approach ('I'm not going round justifying what I do to anybody; they don't ask pilots to say, 'Oh well I fly a plane', or they don't ask GPs or consultants to justify every bit of their work, and I'm not doing it'[46]), but many saw that this confusion undermined health visiting and contributed to the lack of recognition. Strangely, some interviewees even described themselves as having not initially understood what the job entailed, and appreciation of the role having developed through experience. One interviewee said that she only felt that she really understood health visiting when she became a mother herself. Interviewees often said that previous experience and personal qualities played a major role in how they operated as a health visitor. For instance, two interviewees were themselves mothers of children with special needs, and said this gave them extra interest and expertise in this field. Experience of other professional roles, such as being a community midwife or running an intensive care unit, gave background knowledge and key skills that interviewees said they relied on every day in their health visiting work. Some interviewees acknowledged that because the work had many facets this meant that it was difficult to define exactly what a health visitor did.

Another aspect of the health visitor role which contributed to its invisibility was the traditionally high level of autonomy health visitors enjoyed. This was partly because work was done without supervision in the home environment, but also because health visitors had great flexibility in choosing how they worked with families. As part of the attempt to standardise health visiting, and

[46] Siobhan, North East

link work to the core CHPP, methods were being introduced of making health visitors' work more visible. Many interviewees recognised that the traditional autonomy of health visitors could be abused by incompetent practitioners, and therefore considered more standardisation necessary. However, they also felt that 'reigning in' health visiting reduced job satisfaction, and did not allow health visitors to be responsive to clients and innovative in providing services to meet local needs.

The biggest obstacle to health visitors justifying the value of their work within the NHS was the need to show evidence of effectiveness. The main reason for this was the preventive basis of health visiting. Interviewees pointed out that much of their work was in preventing bad outcomes for children, which was difficult to demonstrate. For instance, a health visitor might support a family whose baby had colic, and thus prevent abuse, or listen to a mother letting off steam about the frustration of her daily life, which improved the psycho-social environment for the children. However, despite the long-term importance of these interventions, a positive outcome is difficult to demonstrate. Health visiting outcomes were described as long term, and thus did not fit into government targets. Health visitors saw little hope of being able to demonstrate a quick fix through health visiting work.

In a climate where effective decisions had to be provided using clinical methods of evaluation health visitors saw themselves as being severely disadvantaged. Most interviewees described being under pressure to prove the effectiveness of the service within the PCT. Due to the extreme and entrenched nature of many clients' health needs, some felt that despite health visiting work being important and worthwhile, its effects were often very difficult to discern, let alone measure. In addition, too little research had been done into health visiting, and what was done was not taken into account when making decisions about the service. Inadequate amounts of

research were seen as a consequence of a female workforce, who were mainly concerned with the practical aspects of their job:

> 'Nurses don't generally blow their own trumpet, women generally don't do research and blow their own trumpet. Doctors sneeze and it's in the BMJ, only academic nurses will go on to do research things.'
> Bridget, South East

Interviewees saw the randomised controlled trial (RCT) as the favoured way of providing evidence on which to base health policy and practice, but considered that this methodology did not lend itself easily to the investigation of the effectiveness of health visiting. Qualitative research was considered more likely to yield data about the how health visiting met the health needs of clients, but was perceived to be a less influential kind of research. Because RCTs had not been done, health visitors faced problems when asked by the PCT to demonstrate the value of their work. Interviewees also showed an awareness that research could be used for political ends. They thought that studies which supported the direction of government policy would be referred to in policy documents and speeches by ministers, while studies with less politically attractive findings were ignored.

Health visiting work was also considered difficult to measure because it had such a broad focus and was responsive to need, rather than concentrating on a defined area. Many interviewees spoke of the lack of boundaries to a health visitor's caseload. Unlike other services, such as GPs or therapists, caseloads had no limits and health visitors could neither 'close their books' nor put new clients on a waiting list, which made demonstrating the demand or need for the service difficult. Only one interviewee said that their trust had defined an optimal caseload number for a full time health visitor, which could be worked out pro-rata for part-timers. Some considered that the all-embracing nature of health visiting could not continue, and thought that it would split into a public health role and a family focused role, creating two

types of health visitors. This would allow health visiting to be more easily defined and measured.

The invisibility of health visiting was considered to be growing. This was because the rolling-out of reduced universal visiting across the country had resulted in fewer children and families benefiting from the service. While some interviewees reported that articulate middle-class clients had successfully fought for the reinstatement of scrapped baby clinics, this was unlikely to continue as expectations of the service decreased. Universal routine visiting was considered a cornerstone of the health visitor's distinctive role:

> 'Once you get in to just targeted visiting then you haven't got anything that anybody else hasn't got really, whereas I think that in our job [we are] very privileged to be able to have contact with every single family in the country. I think that is absolutely huge. It means that we are so well placed to gather information, and disseminate information, and make assessments and be active. Take that away and we are snookered.'
> Kate, South West

Many thought that the more vestigial and unsatisfactory the service became, the less it would be appreciated by clients, until ultimately it would be perceived as serving no purpose:

> 'I think the problem…is [that] if you don't offer a very good service people will stop using it and then it will disappear.'
> Frances, South West

6.4 Conclusion

What is offered to children under the child health promotion programme is profoundly affected by the resources available. Where insufficient resources are allocated, the core programme can be cut, health promotion, prevention and home visiting reduced, and even the health visiting infrastructure eroded. This has contributed to the creation of a paradox where the reduction of the core child health programme has also resulted in a reduction rather than an

increase in targeted services. Reforms to the CHPP do not work alone in affecting the extent of preventive health services for children, but are interrelated with other aspects of organisational change. Few interviewees considered that health visiting services are seen as a priority within the NHS. In these circumstances health visitors often saw themselves as lacking the support of managers and other professional groups, and isolated in trying to meet the health needs of children and families. Confusion was identified between what is dictated within policy and what happens in practice at the level of the PCT. While national policy advocated an increasingly targeted CHPP, many health visitors worked to alleviate the impact of policy change upon the preventive services offered to children and families, by electing to continue to provide a more comprehensive service.

Chapter 7

Discussion and conclusion

7.1 Understanding preventive health services for pre-school children

In the preceding chapters I have presented the background to the origins and evolution of preventive health services for children, and discussed the factors which led to calls for reform in the late 1980s. I have examined the development of the Hall reports and shown how their recommendations have become increasingly influential and finally the basis of national policy. Policy development was examined over time (chapters 1 and 2). Combined with the results of the mixed methods study, this has revealed a hitherto unrecognised disparity between top-down directives on the provision of preventive health services for pre-school children and the reality of what is happening in practice.

The empirical research study aimed to get behind the outer presentation to look at the policy in action, and to discover what kind of service pre-school children and their families are being offered by health visitors. The strength of this study lies in combining the quantitative and qualitative findings to give an insight into the CHPP which has both breadth and depth. I will bring together the findings from both phases of the study, making clear how the combined use of quantitative and qualitative methodologies contributed to an original insight into the implementation of the targeted CHPP. Following this I will give a summary of the limitations of the two-part study in order to make clear the strength of the platform on which the subsequent conclusions are based.

This final chapter will go on to consider the study findings in relation to the targeted versus universal services debate. In the discussion I shall use the findings from both phases of the study, combined with insights from the literature review and my own understanding of the phenomenon of CHPP reform, to draw out and explicate the factors which have contributed to

making the CHPP what it is. I shall view these factors in the light of the revised version of the national CHPP (DH 2008a) and consider which longstanding issues have been addressed and which are still ignored or 'skated over' in policy making and policy implementation. This policy discussion is confined to England, as it is recognised that health policies in the devolved countries have increasingly diverged from the English model.

7.2 The findings from the two-phase mixed methods study

Findings from the use of mixed methods gave insights into the ways in which the implementation of the CHPP affected the practice of health visitors. By combining quantitative and qualitative methodologies, the aim was to gain a nuanced and contextualised picture of current Child Health Promotion Programme practice. It is rare for an area of nursing to be investigated both by a quantitative inquiry and then explored in more depth using a qualitative methodology. The neglect of the views of the health visitor workforce has been a remarkable, and hitherto unexplored, feature of the process of CHPP policy change.

The survey used a large representative sample of UK health visitors which allows the findings to be generalised to the wider health visiting population. A major finding of the survey was that routine health visiting had decreased across all regions, but that targeted services had not increased in parallel. Instead levels of targeting had remained the same. This represents an overall decrease in health visitor contacts with families. As Hutchison (2002) predicted, universal services have been reduced without alternative targeted services being developed. Quantitative methodologies are able to show the effect of policy and practice change, but not the 'why'. Therefore a qualitative study was required to explore in more detail the reality of health visitors practice within the everyday context of their working lives.

The interview study was highly successful in bringing to light issues which health visitors consider to have had a profound effect upon service delivery, but are not commonly apparent to non-practitioners. It provided a nuanced and contextualised background to the CHPP policy reform, illuminating in particular the key move from a universal to a predominantly targeted service. The conceptual framework derived for the qualitative data made an effective means of synthesising the views both of health visitors who viewed policy change positively and felt they were providing an effective service for children, and those whose experience of the policy change was primarily negative. A strength of the interview study was the use of health visitors working in areas of deprivation, which allowed policy and practice to be examined from the perspective of those best placed to perceive the benefits of the policy change for the children they encounter.

The combined data contributed to a picture of current CHPP policy and practice in England which had both breadth and depth. It revealed that there have been widespread changes in the CHPP policy, which will be discussed in greater detail in section 7.4. The findings from both parts of the study will be used to discuss the impact of CHPP policy change upon health visitors practice and the way in which a targeted programme has influenced other aspects of preventive care of well children.

7.3 Limitations of the study

For both parts of the study the limitations relate primarily to the possible inherent bias in sampling. This limitation is more pertinent to the quantitative study which aimed to be representative of the wider population of health visitors, but needs to be taken into account when considering the findings from the qualitative study.

The survey was numerically large, but small in proportion to the total numbers of Nursing and Midwifery Council (NMC) registered health visitors.

For this reason, some caution is needed in extrapolating survey findings to all practising health visitors. It is difficult to ascertain exactly what proportion of practising health visitors took part, as it appears that up to a third of the NMC register may consist of health visitors who are not using their health visiting qualification. As it is not possible to determine how many registered health visitors are currently practising as health visitors, health visitor managers or other early years health practitioners, it is not known what relation the size of the sample bears to the total number of potential respondents. Despite the relatively high response rate, numbers of respondents from some regions, particularly Scotland, were small, thus reducing the generalisability of these findings to the practice of all health visitors across the UK. As a result, the survey findings are considered to be more robustly representative of English health visiting.

Responses to questions among those who completed the questionnaire were variable between job groups, meaning that on some variables there were significant percentages of missing responses. The questionnaire was not equally applicable to all those eligible to complete it; only the statement questions were answered well by all respondents. Questions about the administration of the CHPP were particularly poorly answered by the 'other practitioner' group. When the questionnaire was compiled it was not anticipated that such a range of registered health visitors would be employed in alternative posts in the early years field. The disparity between groups in completing all questions was dealt with by ascertaining on which variables there was a significant difference between missing responses. Where there was a significant difference in missing responses the 'other practitioners' group was excluded from the analysis. In this way inadequate data was excluded from analysis and the rigour of the findings was maintained.

It is not known whether the ideas expressed by interviewees were representative of the wider health visiting population. While the study sample

was the source of rich data, it be must remembered that respondents were in some respects atypical of the health visitor population as a whole (more highly qualified, more likely to work full time and more likely to have a specialist/managerial role[47]). Only a tiny proportion of the health visitors who had completed the survey questionnaire volunteered to take part in the interview study. The restriction of the sample to health visitors working in areas of high health inequalities makes it difficult to work out what percentage of eligible respondents actually participated, as it is not known how many health visitors work in urban areas with high health needs. Indeed it not entirely clear that this is a useful demarcation of types of caseload, as several interviewees had mixed caseloads, and it may be that few caseloads consist of uniformly disadvantaged clients. As the sample inevitably included mixed caseloads, a wider sample of health visitors could potentially have been recruited.

When the interviews were analysed it was apparent that there were more interviewees who were generally dissatisfied with the child health promotion programme (CHPP) than who felt it was working well. However two health visitors (a team leader and a practitioner) described programmes which had been reformed satisfactorily, which demonstrates how the programme can be implemented and delivered in a way that health visitors consider provides a good service to children and families. As the aim of this qualitative research was not to count generally positive and negative responses and compare them, but rather to identify dominant themes in health visitors' discourse, the smaller number of 'positive' views is not necessarily a limiting factor. Irrespective of standpoint on policy change, interviewees discussed aspects of the reform (for instance, the implications of resourcing for the success of the programme, the way change had been implemented and the effect upon children) which could be compared across interviews.

[47] See Chapter 5, section 5.1 for a fuller discussion of the characteristics of the interview study sample.

The final point to make is that this study is limited to health visitors, who are the main administrators and enactors of the programme. Other professionals such as GPs, practice nurses and midwives also contribute to the child health promotion programme. To gain a full picture of the workings of the programme it would be necessary to assess how these additional contributors view the programme, and explore their perspectives on the policy change and implications of practice in providing preventive health services for pre-school children. Similarly the study does not set out to investigate the views of service users, such as children and their families, whose perspectives on the service they receive would be valuable.

7.4 Policy analysis in relation to the targeted vs. universal services debate[48]

The post-1989 reforms of preventive services for well-children had the consequence of steering health visiting towards the provision of a minimum core universal service and an enhanced service for the most socially disadvantaged. In policy terms this reflected the overall shift in welfare provision from an attempt to provide comprehensive universal services to a deliberately selective distribution of welfare resources (Graham and Kelly 2004). In this thesis I have shown how services for well children became a targeted rather than a universal service, impacting upon the provision of universal health visiting services as well as the CHPP itself.

Taking as its focus the move from a universal to a targeted CHPP and the significance of this major policy shift, this study has shown the factors that shaped policy development. While the reforms of preventive health services for children were based overtly upon the ideology of evidence-based

[48] This analysis is confined to health visiting in England, as numbers of health visitors from other UK countries who contributed to the survey were small, and the interview study consisted only of English health visitors.

medicine, in practice many other factors contributed to their acceptance. Figure 7.1 below shows diagnostically the influences leading to the increased targeting of preventive children's services.

Figure 7.1

Understanding health services for well children: a diagrammatic representation of the main factors contributing to post- 1989 policy shift towards targeted services

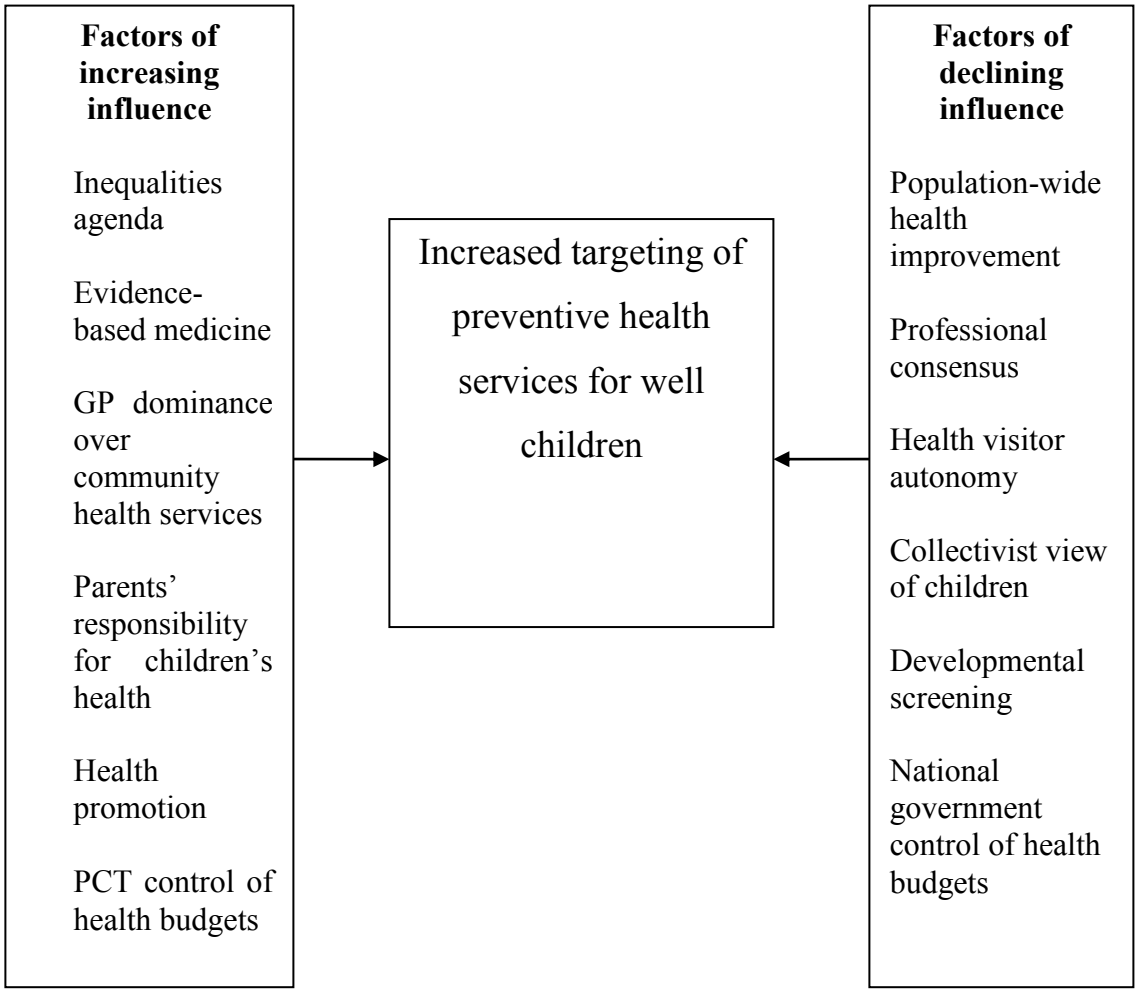


Figure 7.1 shows that factors which were instrumental at the inception of children's services, such as ideas about the collective responsibility for children and the importance of population-wide public health measures (see chapter 1) have decreased in influence. Similarly on the wane, were ideas about the importance of developmental screening (most dominant at the time of the Court report) which had served to justify the provision of comprehensive services. From the 1980s the ideology of evidence-based medicine began to impact upon clinical practice, and by extension health policy. Finally, the inequalities agenda lent itself to an argument that even preventive health services should be directed at the most socio-economically disadvantaged, rather than aiming to provide an equivalent service to all children. These ideas, which arose in the literature review and have run through this thesis, will be discussed in greater detail below as part of an overall consideration of the study findings.

7.4.1 The effects of a targeted CHPP upon health visiting

In health visiting literature the impact of a move from universal to targeted services has been debated (Elkan *et al* 2001, Robinson 1998), with particular reference to effects upon children's health and well being. However this debate had little influence upon the implementation of a targeted regime in practice. It was feared by practitioners that the imposition of a less comprehensive universal service would result in a poorer service for children (Hutchison 2002, Kelsey and Robinson 1999). This was borne out by the empirical findings from this study which showed that routine contacts with children have decreased, while targeted services have not proportionally increased.

Talbot-Smith and Pollock (2006) have described the system of National Service Frameworks as a 'blueprint' for the way services are provided in the NHS by health care professionals. The intention in setting out a core child health promotion programme in the NSF for Children (DH 2004a) was to set a standard for children's preventive health services. By this means it has sought to define and control exactly what interventions are provided for which children. In this way the CHPP has gained stature from being a recommended programme of interventions at key developmental stages, to becoming the sole dictator of what services should be provided for children. In combination with strict resource management within PCTs, this has meant that what is not contained within the programme will not be commissioned and will not be done. This has limited the service provided, theoretically, to what is continued within the national programme, but the reality of what has happened in practice requires closer examination.

It is unquestionable that the reforms to the CHPP have been widely implemented. The survey showed that almost all local CHPPs had been revised in some way, most within the last five years. Changes made veer towards increased targeting and fewer routine contacts with children, particularly a reduction in home visiting. However, where changes have been made these are not consistently in line with national policy. Local policies do not necessarily follow the CHPP, nor does the health promotion service offered by health visitors. Local factors (e.g. strong views of local health professionals) could result in either more or less universal contacts being offered than the national programme. The extent of targeting, and the level of need at which targeting was introduced, varies greatly between geographical areas. Widespread change has not resulted in a standardised service in the way envisaged in the National Service Framework model. It appears that there is a complex relationship between CHPP policy and practice, which goes beyond a simple translation of national to local policy, and hence practice.

When considering the implementation of the CHPP it is important to consider both the CHPP laid down in the National Service Framework, and the CHPP in action, as this study has shown that these are potentially two very different programmes. Interview findings revealed that revision was not simply a one-off action, but that the CHPP could be in a continual state of reform. In a few cases this was because the minimal programme as laid down in the NSF for Children had been tried, but found to leave too many problems undiagnosed until school entry, so a more comprehensive service was reinstated. Most commonly, revision took place because PCT amalgamation meant that different programmes had to be reconciled to a single standard, or because staffing levels were too low to provide the level of service laid down in the current CHPP, hence it was reduced. In all cases some health visitors did not follow the local CHPP laid down, either because they did not believe it was good practice, or because they were unable to provide such a comprehensive service due to lack of time and staff. It appears that political forces within and upon PCTs continue to foster a changeable, non-standardised, non-consistently implemented CHPP.

Lipsky's (1980) 'street level bureacracy' theory is often used to understand health and social care professionals' behaviour when official policy conflicts with the reality of practice (Wells 1997, Corazzini 2000, Evans and Harris 2004, Allen, Griffiths and Lyne 2004, Bergen and While 2005). This theory, which was developed to understand the behaviour of front-line staff in public service agencies, casts useful light on the behaviour of health visitors in delivering the CHPP. On the simplest level it is apparent that health visitors do have autonomy in providing the service which meets their ideas of what should be provided for clients, rather than what policy dictates. In this way health visitors become the creators rather than the translators of policy, because they adjust the service they provide in their essentially private encounters with families according to their own perspective of need, desert

and eligibility. Lipsky (1980) points out that those who work at 'the sharp end of welfare activity' have considerable jurisdiction over how they manage their work, but that this considerable power is rarely recognised by legislators and high-ranking policy makers. Even where good preconditions for implementation are in place (a good chain of command, well-defined objectives, adequate resources and a communication and monitoring system), policies can be implemented in ways that policy makers had not intended (Buse, Mays and Walt 2005).

At a more complex level practitioners act as 'street level bureaucrats' because in their daily dealings with clients they are required to make decisions about how resources are distributed (Lipsky 1980). Street level bureaucrats invariably work within a situation of low support, inadequate resources for the task, and ambiguous and often unattainable expectations of performance (Hill 1997). In explaining different levels of service provision, both practitioners and managers cite the necessity of health visitors using their 'professional judgement' to decide on level of need, and, within competing demands, to decide who warrants a more extensive service. The stress upon 'professional judgement' serves two ends. For practitioners it is the mechanism by which they direct their services to those they consider most worthy of them, sometimes working outside the boundaries of local policy to respond to the needs and demands of the people they encounter. For managers it serves the purpose of legitimately making practitioners prioritise between competing needs in order to match need to resource provision. This study has shown that health visitors do not act as modifiers of government policy in isolation. Where the service must be fitted to the resources available, health visitors' 'bending' of policy is sanctioned, and indeed prescribed, by their employing PCTs in order to provide a service which can be afforded within PCT budgets.

A by-product of the CHPP given in the English National Service Framework is that it has progressively defined what services health visitors provide, limiting the autonomy of health visitors to allocate their time and resources according to the needs they perceive among their clientele. Many health visitors have experienced conflict between fulfilling their professional responsibilities to patients, while making decisions about how needs are prioritised. This conflict has led to variations in the way national policy is delivered in practice. Perry (1993) describes the role of resolving conflicts between nursing values and the imperatives of service delivery as one of nursing's 'hidden agendas', by which nurses are socialised and habituated to act in unacknowledged ways to maintain the status quo and conceal inequalities. The core programme provides a rationale and criteria for limiting health services, which otherwise the practitioner, following their professional code of responsibility to the patient, might distribute too freely (Harrison 2000). Local policy itself is affected by a variety of street level bureaucrats (managers as well as practitioners) who modify its demands, and what is defined at a local level may or may not be delivered accurately. In this way the centralised control of the National Service Framework is subverted both by practitioners failing to modify their practice, and by PCTs as the intermediate institution, which does not choose to (or cannot) provide the resources to fully fund the CHPP.

7.4.2 The effects of a targeted CHPP upon children's health

Here it is necessary to make a distinction between the CHPPs which worked well and those which health visitors described as unsuccessful. Where CHPPs were described as successful the programme did not necessarily completely match the CHPP in the National Service Framework, but health visitors felt that they provided a good service to their clients, and that the reform of the programme had resulted in a service which allowed appropriate targeting according to need. Where programmes worked well health visitors had been involved in the consultation process, the CHPP was flexible and

allowed for the needs of not only the most severely disadvantaged, and there was not an acute lack of resources. Health visitors who were at ease with a more targeted service described local debate and openness between management and staff about how a targeted service should be delivered in order to meet local needs.

Criticism of the CHPP by health visitors was linked to inadequacy of resourcing, but there was also trenchant criticism of ineluctable flaws in the national policy. These flaws arose from misconceptions about how health visitors work and also a lack of understanding of the health and social needs of the children and families they work with. The main points, which are all fundamentally linked to the targeting ethos, are summarised below:

- Targeting is not a simple matter. Health visitors found it difficult to target their services without a period of getting to know families, and without some routine visiting health visitors were unable to make judgements about families. This is supported by a recent paper from Scotland (Wright *et al* 2009) which showed that in a climate where health visitors had relative freedom to visit as they wished (the Starting Well project) most families at risk were not identified on a individual basis in the early weeks. The authors recommended that most families in deprived areas need continued input if vulnerable families are to be reliably identified (Wright *et al* 2009).

- Where PCTs were looking to save money on preventive health services there was pressure to set very high thresholds for targeting. This meant that health visitors were having very limited involvement with families with complex problems, who were often reluctant to engage with welfare services. Traditionally health visitors have used such strategies as making a relationship with families and using fringe work which paves the way for therapeutic work (Dingwall 1982, de la

Cuesta 1993, Davies 1997). Instead the emphasis on early targeting chanelled health visitors into a concentration on their assessment agenda, rather than the clients' own agenda of need. This links with Dingwall and Robinson's view (1993) that attending to the client's agenda is a prerequisite of the health visiting service being accepted by families.

- Many health visitors spoke of the 'bottomless' level of need in health visiting caseloads, a situation exacerbated by the lack of thresholds or other boundaries to the health visiting service. Whereas other services (such as GPs or social services) were perceived as being able to 'close their books' or raise their criteria for providing a service when they were overwhelmed by need, health visitors were always bound to provide a service for the clients in their area of responsibility, generally all children 0-5 years. Elkan *et al* (2001), in their defence of a universal health visiting service, cite the epidemiological work of Rose (1993) who made the point that most need occurs on the untargeted majority rather than in the targeted minority. Health visitors in this study supported this argument for universal child health services, because it is not obvious who to target amidst ubiquitous need.

- Chillingly, some interviewees suggest that pressure was put upon health visitors by managers and child protection supervisors to downplay needs, when there was not the capacity to meet them. This even happened with the most vulnerable families where the health visitor had concerns about developing or incipient child protection issues. In a situation where need is downplayed, overt child protection issues can become the baseline for targeting. This was supported by the survey findings which showed the 'Framework for the Assessment of Children in Need' (DH 2000a) being used in assessing need for the targeted CHPP. As GPs do not focus on children health promotion to

the same extent as health visitors in their contacts with children (Sanderson *et al* 2001), this means that if health visitors do not seek a face-to-face contact with children at set ages, children's health promotion needs can remain unrecognised after the primary assessment contact.

- Many health visitors felt the reduction in universal contacts with children reduced their ability to do child protection work. As described by Robinson (1998, p96) health visitors have a 'universal/generalist, case-finding, support-giving and educative' approach to their clients. Interviewees saw no clear distinction between child protection and support for other difficulties within the home, such as parental mental health problems, substance misuse, violence within the family and home safety. Instead these issues were intricately bound together and represented a continuum of involvement with the family. This supports Lupton, North and Khan's view (2001) that there has been insufficient consideration of the effect of reduced routine child health surveillance contacts upon health visitors' child protection work. Barlow and Stewart-Brown (2003), while not specifically referring to health visitors, support the need for universal parent-support services in order to safeguard children effectively.

There was concern among many health visitors that the CHPP which they followed did not adequately meet the needs of children. It was not only children with unexceptional health needs who were felt to be losing out, but also children living in severely disadvantaged circumstances. Targeting, in the form it was being implemented, did not serve to meet children's health promotion needs, and the situation was made worse when there was a financial squeeze on health visiting. Interviewees described a range of clients being actively denied a targeted service under the CHPP in force, including mothers and children in a Women's Refuge, babies born prematurely, Asian

families and new mothers struggling with breastfeeding. Some thought that creating a situation where health visitors see children and families less, and leave them to define their own needs and seek help appropriately, was an excellent way of suppressing demand on services and reducing costs to the professionals' employing organisation. Health promotion activities in particular were likely to be stopped. Many interviewees described a situation in which the dominant influence on the shape and extent of the CHPP in many PCTs was affordability, rather than the quality of the service provided for children.

Robinson's paper (1998) on the historical and epistemological nature of health visiting is helpful in understanding the conflict aroused in health visiting by the targeted CHPP. As pointed out by Cowley and Houston (2004) targeting is in conflict with an alternative governmental focus on support for all families. Health visitors in this study emphasised that post-natal depression and domestic violence were prevalent among people from all backgrounds and levels of prosperity. Whereas the targeting approach, focuses on very crude measures of need (mainly poverty and child protection), many of the 'low level' problems encountered by parents, such as children's diet and infant/maternal mental health, are the very problems which the government most seeks to address within a public health agenda (Cowley and Houston 2004). As described by Robinson (1998) health visitors are constitutionally unable to offer a less than universal service, because such a service would not be a 'health visiting' service, and would lose the widespread acceptance it has traditionally enjoyed.

7.5 Policy analysis in relation to the revised 2008 CHPP

Further analysis of the findings is presented in the form of a critique of current new developments in CHPP policy in England. The remainder of the chapter is concerned with the implications of the study findings for future child health policy. These combined mixed methods study findings have shed

light upon the direction of future policy. Below the findings are used in an examination of the revised Child Health Promotion Programme for England. The themes which have run through this thesis of targeting, policy implementation, ideologies of childhood and the professional role of health visitors are reprised in this section.

The publication of a revised CHPP for England (DH 2008a) suggests a recognition at government level that the CHPP is not working as intended, and that some changes must be made. The revised programme is said to have been produced in response to criticisms that the CHPP is given a low priority in some parts of the country, and to health visitors and paediatricians reporting difficulties in 'providing a universal service which meets the needs of vulnerable children and families' (DH 2008a, p2). The policy document gives a table of the main changes that have been made since the previous CHPP (see appendix 7.1). These are primarily ideological changes which are intended to result in changed practice at PCT level.

The recommended changes can be put into three groups: those relating to the treatment of children, those relating to the administration of the programme and changes to the commissioning of the programme. Firstly, the new CHPP (DH 2008a) sets out a new approach to children. Instead of a focus on the child, the family are to be viewed more as part of the picture, particularly the father. A stronger emphasis will be placed upon support in early parenting because there is substantial recognition that early psychological experiences have an impact on of the long term mental and behavioural development of the child. Therefore, instead of merely looking at current harm, future risks should be anticipated and services offered accordingly. Families described as in need of an enhanced service are wide. These include young parents, poor parents, those with no educational qualifications or who are unemployed, parents with a history of domestic violence, anti-social or offending behaviour, poor mental health, alcohol

misuse, and those in poor housing, as well as those who are stressed, have low self-esteem or who are ambivalent about parenting. This signifies an enormous widening of the scope of the programme, and a move away from strict targeting to the most severe needs. It is suggested that lower level needs must be taken into account in order to prevent future harm (DH 2008a).

Secondly, the revised CHPP is very clear that the health visitor should lead the CHPP. This work should be in partnership with other organisations, notably general practice and children's centres, but also linked health services, such as school health and child and adolescent mental health services. It firmly places the health visitor back at the forefront of programme delivery, and attempts to locate the programme both within local council-provided Children's Services and primary health care services. An extensive section of an appendix (Annex B) is devoted to the 'agreed and defined lead role for the health visitor' (DH 2008a, p66), which links this newly defined role to the recent review of the future of health visiting ('Facing the Future', DH 2007a). A possible sting in the tail for health visitors is that there will be 'regular supervision and monitoring of quality and outcomes of teams and individual practitioners', in place of 'minimal supervision of staff or focus on outcomes or quality improvement' (DH 2008a, p13).

Thirdly, and perhaps most significantly, the revised programme is clearly meant to be a departure from the old in being properly commissioned and resourced. The first two factors on the list are[49]:

[49] The full table (from 'The Child Health Promotion Programme: pregnancy and the first five years of life', DH 2008a, p13) is given in appendix 7.1.

Moving the CHPP from	…to
commissioning a minimum core programme	commissioning a universal core programme, plus programmes and services to meet different levels of needs and risk
variation of provision according to local investment	variation of provision according to levels of need and risk

There is recognition here that due to financial pressures in many cases only a minimum service was being commissioned rather than a service intended to meet extended needs. Additionally it is recognised that there have been problems in providing a service even as comprehensive as the 2004 programme, because there have been insufficient resources allocated at a local level. It is implicitly admitted that the programme was overly targeted, and failed to function as a preventive health service for pre-school children. The above statements about meeting the needs of children suggest that a wider universal service is envisaged and that there is an intention that this service should be fully resourced. It is recommended that a universal review at two years of age should be reinstated, as there is now seen to be a need for 'greater emphasis' on making contact with children at this age point (DH 2008a, p17).

These changes to the new 2008 CHPP are a welcome response to the deficiencies of the first national CHPP. Given that changes have been made to the CHPP, many of which address issues raised as professional concerns by health visitors, it may seem that there is no longer a problem with the CHPP. However, what is interesting about the revised CHPP as a response to the recognised problems both inherent in the programme, and resulting from implementation, is that several fundamental philosophical issues remain unresolved. Although these issues relate profoundly to the very structure of the programme they are omitted from discussion of the reformed programme (DH 2008a) and remain inherently unrecognised. In the final part of this

discussion I will uncover these issues and debate the reasons for their lack of recognition.

7.5.1 The outstanding issues

The new revised CHPP in England aims to provide a fully-commissioned service, led by health visitors, with a lower threshold for targeting of children with health promotion needs. But will this new programme be implemented in practice? There is no assurance that simply setting new guidelines will result in changes in practice. This is because the use of guidelines to change practice remains a questionable means of bringing about change (Buse, Mays and Walt 2005), and because successful implementation relies upon collaboration between a range of people, including practitioners, service commissioners and service users (Renfrew *et al* 2008). In the case of the revised CHPP, collaboration is needed between health service purchasers and providers, at a time when the future commissioning of community nursing services is in a state of uncertainty (Talbot-Smith and Pollock 2006[50]). In their study of the implementation of two NSFs in GP practices, Checkland, Harrison and Marshall (2007) suggest that rather than simple 'barriers to change' (such as not having time to read policy documents or to apply recommendations to clinical practice), the real obstacles to implementation are the 'underlying organisational realities' which make local health services resistant to the imposition of policy from above. It is these underlying realities and their potential to influence the implementation of the revised CHPP which are examined below.

[50] It is not known who in the future will be the employer of health visitors. According to Talbot-Smith and Pollock (2006, p49); 'The Department of Health has…stated its intention that by December 2008 PCTs will provide services only when these cannot be commissioned or 'purchased' from other providers…it remains unclear who will provide services such as health visitors.'

7.5.1.1 Implementing national policy at a local level

The recent review of health visiting, 'Facing the Future' (DH 2007a), conceded that the way forward for health visitors may be to take a managerial and child protection focused role ('it is for health visitors to do the difficult things'). However, the revised CHPP, as well as the 'Government response to 'Facing the Future'' (DH 2007b), insists that health visitors should actually be involved in working with families as skilled practitioners at a grassroots level. This new opportunity also presents new challenges for health visitors. The question is not now 'Will health visitors change their practice?' but 'Will changes be made that allow health visitors to work in the way laid down in the policy?' Rather than resistance from health visitors obstructing the implementation of national CHPP policy at a local level, barriers to full implementation of the revised CHPP exist at an organisational level. Three inherent problems are outlined below.

Firstly, health visitors will not be able to lead the new CHPP if they are not locally commissioned to do so. Despite the policy message that health visitors will lead the programme, there are no assurances in national policy that the health visiting service must be commissioned. Instead local commissioners are urged to consider the roles that health visitors can play in delivering services for pre-school children, when making decisions about what services are needed to deliver these priorities, but with no guarantees that their services will be required.

> 'It is for local commissioners working with providers, both NHS and local authority, to decide how services should be provided, resourced and delivered in order to meet PSA [Public Sector Agreement] targets.'
> Government Response to 'Facing the Future' (DH 2007b, p7)

In conditions of uncertainty about the future of health visiting services (Talbot-Smith and Pollock 2006), it seems likely that at a local level health visitors must make a convincing argument to commissioners of the need for

their services. In leaving this argument to be made within PCTs by health visitors the government fails to take into account the relative powerlessness of health visitors to influence local service provision. It is known that health visitors experience difficulty in defending their practice in a health service driven by the ideology of meeting targets, measuring outcomes and satisfying consumers of services. Unless the government takes steps to address the PCTs' tendency to see health visiting services as an easy target for cost savings, it is not likely that this comprehensive universal role will become a reality.

Interviewees reported that in some areas GPs have already begun to commission health visiting services under the practice-based commissioning initiative. This situation rings alarm bells for many health visitors because of the different traditions of service provision between GPs and health visitors. While health visitors have taken a predominantly public health approach, based on meeting the needs of the local population, GPs have always provided a service for their registered patients. Many GPs are known to be generally unenthusiastic about health promotion within general practice (Fitzpatrick 2006). A study which examined the commissioning activities of fundholding GPs (Symonds 1997) concluded that GPs were unlikely to commission health visiting in its current form because they did not understand the service, and had little appreciation of the work that health visitors did. It is likely that these attitudes will pose a problem for the provision of the CHPP if commissioning of health visiting services becomes the remit of GPs.

The second problem also relates to the challenges health visitors face in leading the CHPP. Health visitors do not have a literal or metaphorical 'place' within the wider field of pre-school children's services, either with GPs or Children's Centres. This casts doubt on how effectively health visitors will be able to champion the CHPP at a local level. The lack of 'place' for health

visiting was raised as a difficulty in the recent national review of health visiting (DH 2007a), and guidance requested on how health visitors should work in partnership across the health and local authority services. The 'Government Response' (DH 2007b) gave an airy reply to this heartfelt plea, saying that, as professionals, health visitors should be able to work competently both with GPs and with Children's Centre and that the fine detail of where health visitors are based must be left to each local area to work out for itself. As shown in Chapter 6 this question has very real implications for health visitors who, across the country, are losing their office and consulting spaces in GP surgeries and are thus having to find alternative accommodation. Lack of strategic coordination between different providers of children's services policy, specifically between health and local authority children's services have literally left health visitors with no place to go. The revised CHPP appears to assume that health visitors can continue their traditional role of being an approachable professional resource for families and key players in early years' services, without providing an infrastructure within which they can feasibly carry out this role.

The third problem relates to the level of service that will be commissioned, and the level at which targeting will be set. Although the new CHPP advocates comprehensive targeting, even down to the level of parents who are ambivalent about parenting, it is known that in practice, PCTs have chosen to set a high threshold for targeting. Examples were given of where PCTs had failed to see the value of providing targeted health visiting services for the most vulnerable clients. Again these concerns were heightened when health visitors considered GPs as the future commissioners of health visiting services. There is evidence from this study that some GPs avoid referrals to secondary services where possible, and use less qualified nurses in place of health visitors to reduce costs. The needs of groups such as the homeless and gypsies and travellers, are mentioned in the new revised CHPP (DH 2008a) as being of high priority, but if GPs are to commission and fund

health visiting, can it be assumed that GPs will see the relevance of these services (which are not currently included in GP targets) and fund them accordingly? If the commissioning functions and budgets of PCTs are contracted out to the private sector as stated in the White Paper 'Our Health, Our Care, Our Say' (DH 2006) there is more uncertainty that commissioners will choose to extend targeted services (Talbot-Smith and Pollock 2006).

7.5.1.2 Targeting, prioritisation and rationing

It is often pointed out that prioritisation and rationing are two sides of the same coin;

> 'While everyone is keen to talk about priorities, there is a conspicuous reluctance to talk about rationing. Priority talk suggests boldness in making tough choices; rationing talk suggests inadequacy of provision. Priorities are what ministers boast of; rationing is what opposition politicians accuse them of…while setting priorities may imply rationing, it does not make the consequences of the resource allocation decisions transparent.'
> (Klein, Day and Redmayne (1996, p66)

This study has revealed that, where resources are stretched, prioritisation is set at a very high level. The net result of the pre-2008 reforms of the revised CHPP has been to reduce the preventive health services offered to children. This has resulted in a post-code lottery for health visitor services according to what PCTs are prepared or able to fund (Gimson 2007). It is a particular irony that a major factor contributing to the development of the NSF for Children (DH 2004a) was the Laming report, which reported on the circumstances leading to the death of Victoria Climbié, including the failures of health services to identify that she was being abused. In conjunction with other pressures on PCTs, the effect of enforcing the core CHPP has been to reduce routine surveillance of children.

Many interviewees stated that their employing PCTs chose to commission the minimum service, rather than an extended service intended to meet needs of children for whom they have responsibility. Pickard and Sheaff

(1999) point out that PCTs have a rationing function, although this is not as yet publicly acknowledged. Where there is a mismatch between patient needs or demands, and availability of services, PCTs have to make decisions about prioritisation. It appears from this research that PCTs are not at ease with their rationing function. They follow government policy in targeting those with the highest need (which also helps in reducing costs of universal services) but they show unease and lack of conviction when the reduction in universal services is made overt[51]. In a post-Fordist movement of accountability from the centre, PCTs are intended to be in a position to promote health in a wider sense, by engaging with other agencies to address the underlying social, environmental and economic factors that impact on the health of the population (Baggott 2004). However, when resources must be spread thinly, preventive healthy services are often the first target for reductions. In devolving resource allocation from the centre the government has allowed the PCTs freedom to cut their coat according to their cloth, and in a dispiriting number of cases this has resulted in cuts to community children's services. Cuts have been allowed to lie where they fall by central government.

The problem of how to meet national guidelines while also attending to local needs, is one that has been recognised as increasingly important within the NHS (Ham 2004). Children's preventive health services are a good example of the tensions between centralised control and local decision-making. There is a major unresolved question about how local PCTs will marry the requirement to follow national guidance from NICE, NSFs and other sources, with their increasing obligation to meet local priorities, and the demands of local consumers. Paradoxically the emphasis on local flexibility has been accompanied by further centralisation in the allocation of resources (Baggott 2004). Funding formulae that reflect national priorities and ear marking of

[51] This is exemplified by the haste with which services, such as baby clinics, are reinstated when articulate mothers, who live in areas of low health needs, complain about service cuts.

funds for specific central initiatives, has meant that trusts have fewer resources to allocate at their own discretion in order to meet local health needs. Decisions about the allocation of clinical resources continue to be made primarily by clinicians. Ham (2004) suggests that this means of deciding how to target resources is very much favoured by the government, but it leads to a potential conflict between the needs indentified by local professionals and the needs identified as the highest priority at a national level. By linking funding to meeting national targets, the government seeks to circumscribe the behaviour of professionals, but also relies on them to prioritise in their daily work. This is a conundrum that is left to be resolved at a local level.

The way in which practitioners manage the mismatch between supply and demand necessitates more thought, especially when decisions are being made about children who are the recipients of services which they are reliant upon their carers to access. Demand can either be a professional response to the child's needs, or a request made by the child's parent or representative for services. Health visitors have been left to flounder with the ethical dilemma of how to target children's preventive health services, a dilemma which is presented in policy as unproblematic. Health visitors' difficulties are compounded by their close contact with clients and their professional remit to seek out health needs, which must be reconciled with the requirement to limit the extent of services. Like doctors, health visitors' professional values demand that the best service is provided for the individual patient, rather then weighing the competing needs of many patients (Smith and Morrissy 1994), an ethic which conflicts with the institutional demand to provide services within a budget. As health visitors have not been performance-managed or incentivised in the same way as doctors, they do not have the same pressures to work in government-approved ways. Many health visitors in both the survey and the interview study showed reluctance to compromise

their professional standards in order to follow a CHPP which they did not see as meeting the needs of children.

Different approaches could be taken to the problem of how to balance demand for services with supply. Wilmot (2003) argues that rationing needs to be done according to ethical principles, not according to political expediency or convenience. Debate in the issue is hampered by the traditional secrecy about how this conundrum is resolved, and government acceptance that it will be done covertly by GPs. Centralised initiatives to ensure quality, such as NICE and clinical guidelines, militate against doctors continuing to carry out unofficial rationing and bring the issue to public attention. When public concern attracts media attention this is generally at the level of individuals demanding the right for curative treatments, rather than debate about how to meet the health needs of the most vulnerable groups. In the NHS the reality of rationing is rarely made overt to health service users. Coast *et al* (2002) suggest that if rationing is to be an inescapable feature of front-line practitioners' role within the health service, then thought needs to be given as to how this issue is presented to the public. Where service users have been consulted, they appear more prepared than health professionals to question both political choices in providing insufficient funds to the health service, and waste in current use of resources (Coast *et al* 2002). Light and Hughes (2002) describe rationing as a central component of political and social discourses on the allocation of resources, which must be debated rather than presented as an invariable economic fact.

7.5.1.3 Unequal children

Children are not equal to adults because they lack power to demand the opportunities and the services they require. Instead they are reliant upon their parents, and upon society to provide them with what is needed to be healthy. Factors such as whether a child is breastfed, has opportunities to

take exercise, is exposed to cigarette smoke within the home, childhood diet and maternal mental health, have a major impact upon the child's current and future health. Child health promotion services offer an opportunity to improve health for all children by making available to parents information about how to maintain and improve their child's health, and giving them practical help and support to do this. Preventive child health services also provide a means by which health problems can be detected and then treated. The scale of the change to child health promotion services has not been widely recognised and there has been no national outcry about their reduction. When one compares the frequent protests against the 'post-code lottery' of drugs for adults (such as for breast cancer, Alzheimer's disease and kidney failure), with the silence that has met the reduction in children's preventive health services, it highlights the lack of value ascribed both to prevention and to children's health needs. This is particularly striking when it is considered that childhood is a 'once-and-for-all window of opportunity for biological and social development' (Ruxton 1998, p8)[52].

It is instructive here to recall that preventive health services for children in many other rich countries remain much more extensive than in Britain, despite the strictures of evidence-based medicine. This reminds us that there is not only one way of determining which services should be provided for children, instead there are many alternative perspectives from which children's health needs can be viewed. The choice of which CHPP to provide is highly influenced by ideological and political factors, although these are rarely mentioned in health policy. From a children's rights perspective, a liberationist approach could be taken by which children and their families are empowered to identify which services would meet their health needs. In

[52] Kurtz and Tomlinson (1991) describe health as perhaps the 'most valid measure of the sum effect of expression of the values of a society - especially in developed countries where adequate resources are available and where there is choice in how they are deployed' (Kurtz and Tomlinson 1991, p211). They contrast the relative ease with which funds are raised for sick children (e.g. in Great Ormond Street campaigns) with the lack of provision for preventive healthcare, and point out that a fundamental principle of the Convention on the Rights of the Child is that children should have 'first call' upon societal resources, especially to guard and ensure their normal development (Unicef 1991).

common with most countries this approach has not been taken in Britain, instead children are deemed in need of protection, and what children require is decided by health and social care authorities[53].

Within the protectionist paradigm there is little examination of the nature of children's needs, which are seen as obvious and easily assessed. This simplistic view frequently conceals complex assumptions and judgements about children and their position in society (Woodhead 1997, Thomas 2002). Throughout the history of preventive health services for children in the UK those devising and dictating their form have never sought to make radical changes to the living circumstances of children. Despite increasing recognition of the link between social disadvantage and ill health (DH 2008b), structural determinants of health (such as housing, environmental pollution, road traffic risks and access to safe play areas) remain largely unaddressed, in a political climate where the greatest emphasis is put on individual 'lifestyle' choices (DH 2004c).

Big questions remain over whether targeting child health promotion is the best way of providing health services for well-children. Although the new Labour government has focused on improving the lot of children by means of an inequalities agenda, it is not known how effectively the NHS can redress health inequalities which arise from circumstances outside its control. Exworthy and Powell (2000) have examined the often hidden difficulties of a health inequalities approach, which they identify as being more problematic than implied in the policy rhetoric. They detect a lack of clarity about the causes of many health inequalities and the mechanisms by which they might be reduced, and little progress in exploring these issues. Despite the New Labour focus on health inequalities, a recent report (DH 2008c) showed that babies who are born to families in routine and manual groups, now have more chance of dying in infancy than ten years ago (a 17% higher than

[53] Eekelaar (1992) suggests that the right to have welfare 'done to one' is no right at all.

average chance in 2007, compared with 13% in 1997). Although overall health is improving, the gap between the health and life expectancy of the most and least affluent groups continues to widen (European Commission 2008, DH 2008b). In a 2007 survey the UK scored lowest out of 21 OECD countries on child well-being (measured on a number of dimensions including material well-being, health and safety, and subjective well-being) (Unicef 2007).

When the CHPP is primarily targeted a laissez-faire approach is taken, by which the child assessed with 'normal' health needs is left to the care of the family, and depends on its parents for identifying the child's developmental needs and difficulties and seeking help for them appropriately. Within this ideology parents take responsibility for prioritising their children's health needs and are expected to make adequate health provision according to their own judgement. Some claim that this societal expectation takes insufficient account of the disadvantage experienced by many parents. Lyon and Parton (1995) suggest that in order to perform this role successfully parents need to achieve a modicum of equality themselves, which could require the provision of adequate social benefits, access to day care, and employment rights which acknowledge the existence and rights of children. Where it is deemed that a child cannot be left solely to his or her parents' oversight, the child become 'targeted' and is seen as a suitable recipient of the State's surveillance. Within this paradigm children are cast as citizens without rights, who are not important to society as individuals but only as a potential future risk to be averted. Hendrick (2003) detects the identification of children 'at risk' as a dominant theme in current child welfare policy, and describes much of new Labour social policy as being concerned with the socialisation of children, particularly those whose parents are poor and defined as 'socially excluded'.

Foucault (1980) suggests that in an increasingly technological and 'disciplinary' society it becomes ever more important to classify individuals and assign them to their place. The CHPP rests on the ability of health visitors to identify which babies, children and families have high health needs which require targeting, often at a first contact. Preliminary research on the 'pared down' CHPP suggests that mothers dislike being assessed at a first contact and resent being assigned a service according to their socio-economic standing (Roche *et al* 2005). Perversely it appears that instead of reducing the 'Big Brother' elements of surveillance (as intended by Hall 1989a, 1991), targeting preventive health services for children may have increased parental resistance to statutory monitoring of their child's health. Health visitors have always maintained a 'delicate advisory/supervisory role' (Hendrick 1997, p319) in their relations with families. The categorisation and formal assessment of parents poses a threat to this dual role, as it alters the orientation of health visitors from a standpoint of promoting health or 'salutogenesis' (Cowley and Billings 1999), to a standpoint of identifying harm. Oakley (1998) describes health visitors as increasingly caught between a model of care which is about supporting mothers, and a risk assessment model, in which parents are cast primarily as vehicles of risk.

7.5.1.4 Health visitors: professionals without power?

In one sense health visitors' position as street-level bureaucrats within a large institution predisposes them to being professionals without power. In all public services grassroots workers must strive to reconcile professional and institutional values, to manipulate demand to meet supply, and work within institutional guidelines, while seeking to respond to the needs of individuals in a flexible way (Lipsky 1980). It is striking that some of the problems experienced by health visitors in delivering the CHPP (such as a loss of professional autonomy, increased targeting, reduced routine visits and increased crisis visiting) are almost exactly those described by Butler in his 1997 research, and even echo the complaints of health visitors in the 1970s

(Council for the Education and Training of Health Visitors 1977). This suggests that forces of change have been operating for some time, and there has been no recent golden age in which health visitors were able to provide a high-quality comprehensive universal service. Rather than being a new development the reduction in the provision of health visiting services is part of a longstanding process.

Thinking back to Green and Thorogood's policy process framework (see section 0.4), it is apparent that all stages of the development of the CHPP the impetus for change has predominantly come from within the medical profession, and that grassroots health visitors have indeed been 'passengers' in the process. Because health visiting has not been seen as a valuable activity in itself, those who instigated the reform of the CHPP did not take into account the effect of reduced universal contacts on other aspects of health visiting, such the befriending and empowerment of parents in order to facilitate lifestyle changes which will benefit children. The failure to appreciate the work of health visitors is strongly linked to the lack of recognition of the importance of caring work (Salvage 1990, Tudor Hart and Dieppe 1996, Bergen 1999), and the lack of status associated with the work traditionally done by women (Delamothe 1988, Baer 1997). Health visitors' work, which has always been an amorphous and poorly differentiated mix of support and surveillance, is viewed very negatively within the NHS. James (1989) describes how work which requires aptitudes and skills commonly regarded as those natural to women is often seen as worthless:

> 'Women's skills and values are undervalued because they are women's not men's. There exists a distorting divisive conceit through which men are associated positively with rational thought and action while women are negatively associated with emotional reaction. This false distinction facilitates a gender division of labour through which men's labour is understood to be central to the creation of value, while women's work is considered peripheral, subordinated as merely 'support' work, equally marginalised in private and public domains. Though the imperatives of patriarchy and capitalism need emotional labour, it is the dominance of those imperatives which hide and deride both the labour and the labourers.' (James 1989, p40)

The weakness of health visitors' position within the NHS has potentially serous consequences for the successful implementation of the revised 2008 CHPP. Not only do the children for whom the services are provided lack power, as do many of their parents, but also the professionals who are charged with leading the child health promotion programme.

It is puzzling to health visitors how they have found themselves in this situation. The chair of the health visitor review body, Rosalind Lowe, asked in bewilderment:

> 'We have been faced with the question of why the profession seems lost and under pressure when the very issues where health visitors can make a positive difference have never had greater prominence in the public's mind and government policy.' (DH 2007a, p9)

Children's welfare services appear to be moving away from health visiting. The most recent Health Inequalities paper (DH 2008c) describes a wide range of people, often not having a traditional role within the health service, as having a part to play in improving health inequalities. Children's Centres deliver early support to parents, and encourage healthy behaviours via child care and family support staff, while lay workers, such as health trainers, can work with people to bring about behavioural change. 'Facing the Future' (DH 2007a) claimed that the widespread cuts to health visiting had resulted in poorer health services being offered to well-children. In their response the government took a firm stance on whether children have been disadvantaged (DH 2007b), highlighting increased spending on services for children, with £21 billion invested in early years and child care since 1997. The government claimed that the lot of children has improved, and over half a million fewer children were living in relative poverty than in 1997. It also stated that numbers of nurses in the NHS had increased since 1997, and nearly 30,000 more nurses were working in the community. The implication was that the

additional spending on nurses and services for children means that the loss of health visitor numbers is therefore immaterial[54].

As well as not 'fitting in' with the targeted model of preventive health services in the eyes of others, health visitors have trouble in perceiving themselves as fitting in with this model. A fundamental problem with the system of assessment and targeting is that it is antithetical to the way health visitors work. Many health visitors in this study showed a reluctance to assess clients at a first contact and then assign them a service accordingly. Perry (1993) is able to shed some light on this reluctance, pointing out that assessment is alien to nurses, because they wish to work holistically with clients in the context of an ongoing relationship. She suggests that health service management is reluctant to allow nurses to encourage patients to define their own needs, because of the added costs this incurs in providing services;

> 'Personalised caring is time-consuming, labour-intensive, creative and concerned with the patient's self-definition; hence it is expensive and political. Far better that it remain, at present, invisible in health institutions thus perpetuating the dependency of nurses and clients on scientific measurements of need, and not on their own definitions.' (Perry 1993, p48)

The central task of health visiting to 'stimulate awareness of health needs' (Council for the Education and Training of Health Visitors 1977) is seen in a new light in the context of this statement. Health visitors are the only health professionals who are charged with empowering patients to identify their own health needs and to seek out undiscovered health needs. It seems self-evident that in a climate of trying to meet needs within a severely defined budget the last thing that the either national or local health service management wants is for health visitors to work with clients in a way which

[54] Corby and Mathieson (1997) argue that increasing numbers of lower paid support workers in the NHS has served to reduce the number of health professionals in the workforce, and thereby assisted in the resolution of tensions between professional and organisational values. This argument can perhaps be extended to the replacement of more highly paid, highly qualified and experienced health visitors with junior nursing staff and nursery nurses, which is likely to lead to a more compliant and less assertive workforce.

could generate a demand for more services. In the 1990s Dingwall and Robinson (1993) pointed out that the increasingly epidemiological view of communities and populations, and the emphasis on identifying 'high-risk' individuals and families, serves to obscure the self-defined needs of individuals and moves health visiting away from concern with the client's agenda.

It was apparent from the interview study that many health visitors were continuing to try to provide a personalised and caring service for clients, despite the pressures to change their practice from management, and the stress of working in diminished health visiting teams. Kirkpatrick, Ackroyd and Walker's (2005) description of the way in which nurses have been increasingly subordinated under new managerial regimes, is highly relevant to the current state of health visiting. Emphasis on productivity and strict time management has led to nursing work becoming intensified, because, as workers on the front line, much of nurses' work involves managing the expectations of service users. When health services become more pressured and deteriorate, nurses' assuaging and reassuring work increases in parallel. In order to continue to provide the standards of care that their professional values dictate, nurses literally 'work harder' in an attempt to ameliorate the effects of service pressures. This increase in 'emotional labour' (James 1989) has a cost to nurses, who struggle to keep services going, often with little recognition of the value of these services. This study has revealed some health visitors suffering high levels of stress in attempting to provide a safe service for children and families. Health visitors have had to see more clients, and assess them within ever shorter time frames, and so their 'emotional labour' has also increased as they strive to keep clients 'on board' and ensure continued acceptance of the service.

7.6 Conclusion

This study has examined one area of health policy from the perspective of the policy process and has identified the main factors which have led to changes, It has used empirical research to examine the implementation of policy and explored the findings in the light of the targeted versus universal services debate. This policy analysis approach has served to identify the broader factors which have impacted upon reform (see figure 7.1) and has contributed to the understanding of how a targeted CHPP impacts upon the practice of health visitors. A finding of particular importance is the existence of a gap between top down directives and bottom up responses which needs further research.

This policy analysis highlights the often problematic relationship between clinical evidence-base, policy and practice. Within the research literature there is a lack of any evidence of a rational linear relationship between research and policy, and it is recognised that research conclusions can be used in a wide variety of different ways by policy makers (Buse, Mays and Walt 2005). Evidence-based guidelines almost universally focus on evidence obtained from medical research rather than that of other healthcare disciplines, and favour quantitative methodologies over qualitative methodologies, which could give different insights into problems, and inspire different policy solutions (Popay and Williams 1998). As the NHS is an intensely politicised institution, power relations within the NHS can have a disproportionate effect in promoting one policy and subverting another (Salter 1998). Although the link between policy recommendations and practice at the clinical level is tenuous, it is presented within government policy as unproblematic.

What has been missed is that provision of health services, particularly those for children, cannot be based solely on what is termed ‘scientific evidence’. Decisions about what services we are prepared to offer children relate to

moral questions about the relationship between children and society. The use of evidence-based medicine to justify reducing services has obscured the wider implications of the policy decisions made, and has made the service reforms appear the inevitable result of a logical and objective assessment of the situation. Stainton Rogers (1993) points out that decisions about child welfare are not a matter for experts alone, as academics and practitioners have no special resources for making political or moral decisions beyond those that are prevalent in our culture as a whole. However the case of children's preventive health services has not been a matter for wide discussion and the views of dominant medical groups have been allowed to predominate over the views of other stakeholders. This has meant that the more subtle aspects of universal health visiting, such as the links between health promotion and child protection or the need to establish a relationship of trust with parents, have been insufficiently recognised or valued.

The extent to which views on the preventive services offered to children have changed over time, and between countries, is illustrated by this quotation taken from the European Health Committee's recommendations on Child Health Surveillance in 1985:

> 'Surveillance services should cater for all children irrespective of their state of health or family situation…[Services] should therefore be organised in such a way that no distinction is drawn, at any level, between services and measures catering for 'normal children', 'problem children', 'advantaged children' and 'deprived children'. Such compartmentalisation would automatically cause children to be 'labelled' right into adulthood. Child health surveillance should be part of an overall policy benefiting the family.' (European Health Committee (1985, p10)

As demonstrated in the preceding thesis, this view on the desirability of providing universal services is no longer common currency among policy makers in the UK. This has brought about a conflict between what is prescribed in policy and the views of those who deliver the service. Health visitors, for reasons connected with their professional survival, as well as with

what they believe is best for children, still commonly support a universal service. The revised 2008 CHPP programme exemplifies a new conviction about creating services which meet children's health needs. However, poorly recognised factors, representative of long-standing ideological tensions and conflicts in values within the health service, weaken the chances of this new programme being implemented. Without active government enforcement the new CHPP remains merely a 'best-practice' guide (Adams and Newland 2008).

7.7 Implications for policy and future practice

This thesis has given the 'history of a policy'. It has become apparent that a multifarious range of factors have influenced the development and current state of the child health promotion programme. A health visitor's wish list of changes to the current programme would certainly include more investment in preventive health services for children, recognition of the complexity and worth of health visitors' work, and an infrastructure which facilitates the efficient delivery of services to children and families. When considering the future of the CHPP, the major concern must be with the benefits the programme brings for children and families, rather than the future of health visiting as a profession. However, it is arguable that a lack of investment in health visiting represents a lack of investment in children, and a failure to value children's current and future health

Given the high levels of parental acceptance of the 'brand' of British health visiting, it would be short-sighted to allow the profession to decline through under-resourcing. There is currently a lack of political will to ensure that health visitors have a solid place in early years' services. In electing to appoint health visitors as the guardians of the child health promotion programme, the government has sought to continue to rely on the longstanding acceptability of the 'brand', but has neglected to ensure an environment in which health visitors can do the job. Health visiting is reliant

on a negotiated, low-key, friendly approach to mothers, and if this is no longer possible because of pressures to assess, target and reduce service costs, then it is unlikely that health visiting will continue to be considered a useful and tolerable service by families. If health visitors are to have a fighting chance of continuing to provide preventive services for well-children in the 21st century, intelligent action is needed to create the conditions in which national policy can be translated into local practice.

REFERENCES

Acheson D (1998) Inquiry into Inequalities in Health London: The Stationery Office

Adams C and Newland R (2008) 'What the CHPP means' Community Practitioner Vol 81, No 6, pp36-37

Allen D and Lyne P (2006) 'Where are we now?' in Allen D and Lyne P (eds) The Reality of Nursing Research: politics, practices and processes London: Routledge

Allen D, Griffiths L and Lyne P (2004) 'Accommodating health and social care needs: routine resource allocation in stroke rehabilitation' Sociology of Health and Illness 26 (4), 411-432

Allsop J (1995) Health Policy and the NHS: towards 2000 (2nd edition) Harlow: Longman

Altman D and Bland J (1995) 'Absence of evidence is not evidence of absence' British Medical Journal Vol. 311, p 485

Annandale E (2004) 'Working on the front-line: risk culture and nursing in the new NHS' in Burg M and Gabe J (eds) The Sociology of Health and Illness: a reader London: Routledge

Armstrong D (1993) 'From clinical gaze to regime of total health' in Beattie A, Gott M, Jones L and Sidell M (eds) Health and Wellbeing: a reader' Buckingham: Open University

Armstrong A (1983) The Political Anatomy of the Body Cambridge: Cambridge University Press

Ashton J and Seymour H (1988) The New Public Health Buckingham: Open University Press

Audit Commission (1994) Seen But Not Heard: coordinating community child health and social services for children in need London: HMSO

Baer E (1997) 'Women and the politics of career development: the case of nursing' in Rafferty A, Robinson J, and Elkan R (eds) Nursing History and the Politics of Welfare London: Routledge

Baggott R (2004) Health and Healthcare in Britain (3rd edition) Basingstoke: Palgrave

Bain J (1990) 'Child health surveillance' British Medical Journal Vol. 300, pp1381-1382

Bain D (1974) 'The results of developmental screening in general practice' Health Bulletin Vol. 32, no.5, pp189-193

Baker D and Hann M (2001) 'GP services in primary care groups in England: is there inequity between service availability and population need?' Health and Place Vol. 7, pp 67-74

Baly M (1995) Nursing and Social Change (3rd edition) London: Routledge

Barbour R (2008) Introducing Qualitative Research London: Sage

Barlow J and Stewart-Brown S (2003) 'Why a universal population-level approach to the prevention of child abuse is essential' Child Abuse Review Vol. 12, pp279-281

Bax M (1976) 'Developmental assessment is a necessity' Proceedings of the Royal Society of Medicine Vol. 69, page 387-388

Bax M and Whitmore K (1990) 'Health for all children' Archives of Disease in Childhood Vol. 65, pp141-142

BBC News (2008) 'Cameron vows more health visitors' 15/3/08 http://news.bbc.co.uk/1/hi/uk_politics/7297506.stm

Beardshaw V and Robinson R (1990) New for Old? Prospects for nursing in the 1990s London: Kings Fund Institute

Bellman M, Lingam S and Aukett A (1996) Schedule of Growing Skills II Windsor: Nfer-Nelson

Beresford P (2002) 'User involvement in research and evaluation' Social Policy and Society Vol. 1, No. 2, pp95-105

Berg B (1995) Qualitative Research Methods for the Social Sciences (2nd edition) London: Allyn and Bacon

Bergen A (1999) 'Nursing as caring revisited' in Norman I and Cowley S (eds) The Changing Nature of Nursing in a Managerial Age Oxford: Blackwell Science

Bergen A and While A (2005) 'Implementation deficit and street-level bureaucracy: policy, practice and change in the development of community

nursing issues' Health and Social Care in the Community Vol. 13, No. 1, pp1-10

Bhopal R (1993) 'Public health medicine and purchasing health care' British Medical Journal Vol. 306, pp381-382
Billingham K (1991) 'Public health and the community' Health Visitor Vol. 64, No. 2, pp40-43

Billingham K, Morrell J and Billingham C (1996) 'Reflections on the history of health visiting' in British Journal of Community Nursing Vol. 1, No 7, pp386-392

Bilton K (1999) 'Child welfare: whose responsibility?' in Stevenson O (ed) Child Welfare in the UK London: Blackwell Science

Blaxter L, Hughes C and Tight M (1996) How to Research Buckingham: Open University Press

Bloor M and McIntosh (1990) 'Surveillance and concealment: a comparison of techniques of client resistance in therapeutic communities and health visiting' in Cunningham-Burley S and McKeganey N (eds) Readings in Medical Sociology London: Routledge

Boaden N (1997) Primary Care: making connections Buckingham: Open University Press

Botes S (1998) 'The CPHVA view of health visiting and the new NHS' Health Visitor Vol. 71, No. 6, pp220-222

Bowling A (1997) Research Methods in Health Buckingham: Open University Press

Bowns I, Crofts D, Williams T, Rigby A, Hall D and Haining R (2000) 'Levels of satisfaction of 'low risk' mothers with their current health visiting service' Journal of Advanced Nursing Vol. 31, Part 4, pp805-811

Boynton P (2004) 'Administering, analysing and reporting your questionnaire' British Medical Journal Vol. 328, pp1372-1375

Boynton P and Greenhalgh T (2004) 'Selecting, designing and developing your questionnaire' British Medical Journal Vol. 328, pp1312-1315

Bradbury-Jones C and Bates J (2005) 'Health in childhood' in Jones L, Holmes R and Powell J (eds) Early Childhood Studies: a multi-professional perspective Buckingham: Open University Press

Bradley B (1989) Visions of Infancy Oxford: Blackwell

Bremberg S (2000) 'Quality of evidence for the present Swedish child health surveillance programme' Acta Paediatrica Supplementa Vol. 434, pp8-11

Brown B (2006) 'Campaigning together to combat redundancies' Community Practitioner Vol. 79, No. 11, p 377

Brown J, Dezateux C, Karnon K, Parnaby A and Arthur R (2003) 'Efficiency of alternative policy options for screening for developmental dysplasia of the hip in the UK' Archives of Disease in Childhood Vol. 88, pp 760-766

Bryant G (1986) 'Preventive health care for preschool children or health surveillance' Child: Care, Health and Development Vol. 12, pp195-206

Bryman A and Burgess R (1994) 'Reflections on qualitative data analysis' in Bryman A and Burgess R (eds) Analysing Qualitative Data London: Routledge

Buse K, Mays N and Walt G (2005) Making Health Policy Buckingham: Open University Press

Butler J (1997a) 'Child health surveillance in England and Wales: the good news' Child: Care, Health and Development Vol. 23, No. 4, pp327-337

Butler J (1997b) 'Child health surveillance in England and Wales: the bad news' Child; Care, Health and Development Vol. 23, No. 4, pp339-354

Butler J (1989) Child Health Surveillance in Primary Care London: HMSO

Byrd M (1995) 'A concept analysis of home visiting' Public Health Nursing Vol 12, No 2, pp83-89

Cabinet Office (2006) Reaching Out: an action plan on social exclusion London: HM Government

Campbell F, Cowley S and Buttigieg M (1995) Weights and Measures: outcomes and evaluation in health visiting London: Health Visitors Association

Caraher M and McNab M (1997) 'Public health nursing: an alternative viewpoint' Health Visitor Vol 70, no 3, pp105-106

Carlisle D (2003) 'Building the framework' Community Practitioner Vol. 76, No. 6, pp202-203

Chadwick E (1842) 'Report on the sanitary conditions of the labouring population of Great Britain' in Smith G, Dorling D and Shaw M (eds) Poverty, Inequality and Health in Britain1800-2000: a reader Bristol: The Policy Press

Chalmers K (1993) 'Searching for health needs: the work of health visiting' Journal of Advanced Nursing Vol. 18, pp900-911

Chalmers K (1992) 'Giving and receiving: an empirically derived theory on health visiting practice' Journal of Advanced Nursing Vol 17, pp1317-1325

Charmaz K (2002) 'Qualitative interviewing and grounded theory analysis' in Gubrium J and Holstein J (eds) Handbook of Interview Research London: Sage

Checkland K, Harrison S and Marshall M (2007) 'Is the metaphor of 'barriers to change' useful in understanding implementation? Evidence from general practice' Journal of Health Service Research and Policy Vol. 12, No. 2, pp95-99

Clarke K (2006) 'Childhood, parenting and early intervention: a critical examination of the Sure Start national programme' Critical Social Policy Vol. 26, Part 4, pp699-721

Clay T (1987) Nurses, Power and Politics London: Heinemann

Clews G(2009) 'Scotland, Wales and Northern Ireland: new powers' Health Service Journal www.hsj.co.uk/resource-centre/5000551.article

Coast J, Donovan J, Litva A, Eyles J, Morgan K, Shepherd M and Tacchi J (2002) '"If there was a war tomorrow, we'd find the money": contrasting perspectives on the rationing of healthcare' Social Science and Medicine Vol. 54, pp1839-1851

Cochrane A (1972) Effectiveness and Efficiency: random reflections on health services London: Nuffield Provincial Hospitals Trust

Cochrane A and Holland W (1969) 'Validation of screening procedures' British Medical Bulletin Vol. 27, pp3-8

Colver A (1990) 'Health for all children' Archives of Disease in Childhood Vol.65, pp141-142

Community Practitioner (2006) 'Health visitors in decline' Community Practitioner Vol. 79, No. 6, p172

Community Practitioners and Health Visitors Association (1997) Public Health: the role of nurses and health visitors. London: CPHVA

Cook J and Fonow M (1986) 'Knowledge and women's interests: issues of epistemology and methodology in feminist sociological research' Sociological Enquiry Vol. 56, N0. 1, pp2-29

Corazzini K (2000) 'Case management through decision making: goal transformation through discretion and client interpretation' Home Health Care Services Quarterly Vol. 18, No. 3, pp81-96

Corby S and Mathieson H (1997) 'The NHS and the limits to flexibility' Public Policy and Administration Vol 12, No 4, pp60-71

Council for the Education and Training of Health Visitors (1977) An Investigation into the Principles of Health Visiting London: CETHV

Court S (1984) 'Meaning and method in child health surveillance' Journal of the Royal Society of Medicine Vol 77, pp863-865

Court S (1976) The Report of the Committee on Child Health Services: Fit for the Future London: The Stationery Office

Cowley S (2002) 'What's in a name? Health visiting is health visiting' Community Practitioner Vol 75, No 8, pp304-306

Cowley S (1999) The Cambridge experiment- one year on London: CPHVA

Cowley S (1996) 'Achieving positive outcomes: principles and process' Health Visitor Vol. 69, No. 1, pp17-19

Cowley S and Appleton J (2000)'The search for health needs in Appleton J and Cowley S The Search for Health Needs Basingstoke: Palgrave

Cowley S and Houston A (2004) 'Contradictory agendas in health visitor health needs assessment' Primary Health Care Research and Development Vol. 5, pp240-254

Cowley S and Houston A (1999) Health visiting and school nursing: the Croydon story Croydon: Croydon Community Health Council

Cowley S and Billings J (1999) 'Resources revisited: salutogenesis from a lay perspective' Journal of Advanced Nursing Vol. 29, No 4, pp994-1004

Craig P (2002) 'The development of public health nursing' in Cowley S (ed) (2002) Public Health in Policy and Practice London: Balliere Tindall

Craig P and Smith L (1998) 'Health visiting and public health: back to our roots or a new branch?' Health and Social Care in the Community Vol. 6, Part 3, pp172-180

Crinson I (1998) 'Putting patients first: the continuity of the consumerist discourse in health policy, from the radical right to New Labour' Critical Social Policy Vol. 18, No. 2, pp227-238

Cunningham H (1995) Children and Childhood in Western Society since 1500 London: Longman

Davey Smith G, Ebrahim S and Frankel S (2001) 'How policy informs the evidence- 'evidence-based' thinking can lead to debased policy making' British Medical Journal Vol. 322, pp184-185

Davidson R, Hunt K and Kitzinger J (2003) 'Radical blueprint for social change? Media representations of New Labour's policies on public health' Sociology of Health and Illness Vol. 25, No. 6, pp532-552

Davies C (1997) 'Health visiting: women's work in a man's world' Health Visitor Vol. 70, No. 3, pp110-111

Davies C (1995) Gender and the Professional Predicament in Nursing Buckingham: Open University Press

Davies C (1988) 'The health visitor as mother's friend: a woman's place in public health, 1900-1914' The Society of the Social History of Medicine Vol.1, Part 1, pp39-59

Davies H and Nutley S (1999) 'Healthcare: evidence to the fore' in Davies H, Nutley S and Smith P (eds) What Works? Evidence-based policy and practice in public services. Bristol: The Policy Press

Davies H, Nutley S and Smith P (1999) 'What works? The role of evidence in public sector policy and practice' Public Money and Management Vol. 19, No. 1, pp3-5

Davin A (1978) 'Imperialism and Motherhood' History Workshop Journal Vol. 5, pp 9-65

Degeling P, Maxwell S, Kennedy J and Coyle B (2003) 'Medicine, management and modernisation: a 'danse macabre'?' British Medical Journal Vol. 326, pp649-652

de la Cuesta (1994) ‘Relationships in health visiting: enabling and mediating’. International Journal of Nursing Studies Vol. 31, No. 5, pp451-459

de la Cuesta (1993) ‘Fringe work: peripheral work in health visiting’ Sociology of Health and Illness Vol. 15, No. 5, pp 665-682

Delamothe T (1988) ‘Not a profession, not a career’ British Medical Journal Vol. 296, pp271-274

Denny E (2003) ‘The class context of nursing’ in Miers M (ed) Class, Inequalities and Nursing Practice’ Basingstoke: Palgrave Macmillan

Denscombe M (2007) The Good Research Guide Buckingham: Open University Press

Department for Education and Employment (1999) Sure Start London: DfEE

Department of Health (2008a) The Child Health Promotion Programme: pregnancy and the first five years of life London: Department of Health

Department of Health (2008b) Tackling Health Inequalities London: Department of Health

Department of Health (2008c) Health Inequalities: progress and the next steps London: Department of Health

Department of Health (2007a) Facing the Future: a review of the role of health visitors. London: Department of Health

Department of Health (2007b) The Government Response to ‘Facing the Future’: a review of the role of health visitors’ London: Department of Health

Department of Health (2006) Our Health, Our Care London: Department of Health

Department of Health (2005) Report from the National Clinical Director for Children to the Secretary of State for Health - the development of the NSF for children, young people and maternity services London: Department of Health

Department of Health (2004a) National Service Framework for Children, Young People and Maternity Services London: Department of Health

Department of Health (2004b) Supporting Local Delivery London: Department of Health

Department of Health (2004c) Choosing Health London: Department of Health

Department of Health (2003a) Every Child Matters London: Department of Health

Department of Health (2003b) NHS Hospital and Community Health Services Non-Medical Workforce Census London: Department of Health

Department of Health (2001) Health Visitor and School Nurse Practice Development Resource Pack London: Department of Health

Department of Health (2000a) Framework for the Assessment of Children in Need and their Families London: Department of Health

Department of Health (2000b) The NHS Plan London: Department of Health

Department of Health (1999) Saving Lives: our healthier nation London: The Stationery Office

Department of Health, Social Services and Public Safety (2006) Health for all children: guidance and principles of practice for professional staff. http://www.dhsspsni.gov.UK/guidance_and_principles_of_practice_for_professional_staff.pdf

Derret C and Burke L (2006) 'The future of primary care nurses and health visitors' British Medical Journal Vol. 333, pp1185-1186

de Vaus D (1996) Surveys in Social Research (4th edition) London: Routledge

Devlin R (1985) 'Whose job is it anyway?' Nursing Times Vol. 81, Part 11, p18

de Winter M, Balledux M and de Mare J (1997) 'A critical evaluation of Dutch preventive child health care.' Child: Care, Health and Development Vol. 23, No. 6, pp 437-446

de Winter M, Balledux M, de Mare J and Burgmeijer R (1995) Screening in Child Health Care: report of the Dutch working party on child health care. Oxford: Radcliffe Medical Press

Dingwall R (1982) 'Community nursing and civil liberty' Journal of Advanced Nursing Vol. 7, pp337-346

Dingwall R (1979) 'The place of men in nursing' in Colledge M and Jones D (eds) Readings in Nursing Edinburgh: Churchill Livingstone

Dingwall R (1977) 'Collectivism, regionalism and feminism: health visiting and British social policy 1850-1975' Journal of Social Policy No. 6, Part 3, pp291-315

Dingwall R and Eekelaar J (1988) 'Families and the State: an historical perspective on the public regulation of private conduct' Law and Policy Vol.10, No.4, pp341-361

Dingwall R, Rafferty A and Webster C (1988) An Introduction to the Social History of Nursing London: Routledge

Dingwall R and Robinson K (1993) 'Policing the family? Health visiting and the public surveillance of private behaviour' in Beattie A, Gott M, Jones L and Sidell M (eds) Health and Wellbeing: a reader London: Macmillan

Dixon-Woods M, Agarwal S, Jones D, Young B and Sutton A (2005) 'Synthesising qualitative and quantitative evidence: a review of possible methods' Journal of Health Services Research and Policy Vol. 10, No. 1, pp45-53

Donzelot J (1980) The Policing of Families London: Hutchinson

Doyal L (1979) The Political Economy of Health London: Pluto Press

Doyal L, Dowling S and Cameron A (1998) Challenging Practice: an evaluation of four innovatory nursing posts in the South West Bristol: Policy Press

Drillien C and Drummond M (1983) Development Screening and the Child with Special Needs: a population study of 5000 children London: Heinemann

Dwork D (1986) War is Good for Babies and Other Young Children: a history of the infant and child welfare movement in England 1898-1918 London: Tavistock`

Dworkin P (1989) 'British and American recommendations for developmental monitoring: the role of surveillance' Paediatrics Vol. 84, No. 6, pp1000-1009)

Edwards N, Marshall M and McLellan A (2003) 'Doctors and managers: a problem without a solution?' British Medical Journal Vol. 326, pp609-610

Edwards P, Roberts I, Clarke M, DiGuiseppi M, Pratap S, Wentz R and Kwan I (2002) 'Increasing response rates to postal questionnaires: systematic review' British Medical Journal Vol. 324, pp?

Edwards N and Hensher M (1998) 'Managing demand for secondary care services: the changing context' British Medical Journal Vol. 317, pp 135-138

Eekelaar J (1992) 'The importance of thinking that children have rights' in Alston P, Parker S and Seymour J (eds) Children, Rights and the Law Oxford: Clarendon Press

Egger M, Juni P, Bartlett C, Holenstein F and Sterne J (2003) 'How important are comprehensive literature searches and the assessment of trial quality in systematic reviews?' Health Technology Assessment Vol. 7, No. 1

Elkan R, Robinson J, Williams D and Blair M (2001) 'Universal vs. selective services: the case of British health visiting' Journal of Advanced Nursing Vol. 33, No. 1, pp113-119

Elkan R, Kendrick D, Hewitt M, Robinson JJA, Tolley K, Blair M, Dewey M, Williams D and Brummell K. (2000a) 'The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature' Health Technology Assessment Vol. 4, No.13

Elkan R, Robinson J, Blair M, Williams D and Brummell K (2000b) 'The effectiveness of health services: the case of health visiting' Health and Social Care in the Community. Vol. 8, Part 1 pp70-78

Elston M (1991) 'The politics of professional power' in Gabe J, Calman M and Bury M (eds) The Sociology of the Health Service London: Routledge

European Commission (2008) Child Poverty and Well-being in the EU: current status and the way forward Luxembourg: European Commission

European Health Committee (1985) Child Health Surveillance Strasbourg: Council of Europe

Evans T and Harris J (2004) 'Street-level bureaucracy, social work and the (exaggerated) death of discretion' British Journal of Social Work Vol. 34, No. 6, pp871-895

Evans A, Maskrey N and Nolan P (1991) 'Admission to child health surveillance lists: the views of FHSA general managers and general practitioners' British Medical Journal Vol. 303, pp229-232

Exworthy M and Powell M (2000) 'Variations on a theme: New Labour, health inequalities and policy failure' in Hann A (ed) Analysing Health Policy Aldershot: Ashgate

Family and Parenting Institute (2009) Health Visitors: a progress report www.familyandparenting.org/healthVisitors

Fawcett M (2000) 'Early development: Critical perspectives' in Boushel M, Fawcett M and Selwyn J (eds) Focus on Early Childhood London: Blackwell Science

Fielder A (1998) 'Vision Screening' Evolution or Revolution 1998: conference report http://www.health-for-all-children.co.UK

Finch J (1986) Research and Policy: the use of qualitative methods in social and educational research London: Falmer Press

Fitzpatrick M (2006) 'The future of general practice' British Journal of General Practice Vol. 56, p801

Foucault M (1980) Power/knowledge: selected interviews Brighton:Harvester

Foucault M (1977) Discipline and Punish; the birth of the prison London: Penguin

Foucault M (1973) The Birth of the Clinic: an archaeology of medical perception London: Tavistock publications

Foster J (2001) Data analysis using SPSS for Window versions 8 to 10: a beginner's guide London: Sage

Frankenberg W, Dodds J, Archer P, Shapiro P and Breswick B (1992) 'The Denver II: a major revision and restandardization of the Denver developmental screening test' Pediatrics Vol 89, pp91-97

Frazer WM (1950) A History of English Public Health 1834-1939 London: Balliere Tindall and Cox

Gesell A (1950) The First Five Years of Life London: Methuen

Gimson S (2007) Health Visitors- an endangered species London: Family and Parenting Institute

Gillam S, Glickman M, Boyle G and Woodroffe C (1993) 'Cooperation or conflict over CHS? Views of key actors' Quality in Health Care Vol. 2, pp83-86

Glaser B and Strauss A (1967) The Discovery of Grounded Theory: strategies for qualitative research Chicago: Aldine

Goodwin S (1988) 'Whither health visiting?' Health Visitor Vol. 61, pp379-383

Graham H (1979) 'Women's attitudes to the child health service' Health Visitor Vol. 52, pp175-178

Graham H and Kelly M (2004) 'Health inequalities: concepts, frameworks and policy' Briefing Paper London Health Development Agency

Green J and Thorogood N (1998) Analysing Health Policy: a sociological approach London: Longman

Greenhalgh T (2001) How to Read a Paper: the basics of evidence-based medicine London: BMJ Books

Hakim C (1987) Research Design London: Unwin Hyman

Hall D (1998a) 'The history of preventive paediatric care in the UK' Systematic reviews on screening in child health-report of meeting held in London 1998 http://www.health-for-all-children.co.UK

Hall D (1998b) 'Current concerns' Systematic reviews on screening in child health-report of meeting held in London 1998 http://www.health-for-all-children.co.UK

Hall D (ed) (1996) Health for all children: report of the third joint working party on child health surveillance (3rd edition) Oxford: Oxford University Press

Hall D (ed) (1991) Health for all children: a programme for child health surveillance/ report of a joint working party for child health surveillance (2nd edition) Oxford: Oxford University Press

Hall D (ed) (1989a) Health for all children: a programme for child health surveillance/ the report of the joint working party on child health surveillance Oxford: Oxford University Press

Hall D (1989b) 'Ringing the changes in child health' Health Visitor. Vol. 62, pp239-241

Hall D and Bedford H (2003) 'Health surveillance in childhood' Journal of Family Health Care Vol 13, No 6, pp147-149

Hall D and Ellimann D (2003) Health for all children (4th edition) Oxford: Oxford University Press

Hall D and Matthews T (2002) 'Audit and risk management in community child health' Archives of Disease in Childhood Vol. 87, 87-90

Hallett C (2007) 'A gallop through history: nursing in social context' Journal of Clinical Nursing Vol. 16, Issue 3, pp429-430

Ham C (2004) Health Policy in Britain Basingstoke: Palgrave Macmillan

Hamlin C (2002) 'The history and development of public health in developed countries' in Detels R, McEwen J, Beaglehole R and Tanaka H (eds) Oxford Textbook of Public Health (Volume 1) Oxford: Oxford University Press

Hampshire A, Blair M, Crown N, Avery A and Williams E (1999) 'Are child health surveillance reviews just routine examinations of normal children?' British Journal of General Practice Vol. 49, pp981-985

Harding L (1999) 'Children's Rights' in Stevenson O (ed) Child Welfare in the UK London: Blackwell Science

Harrison S (2000) 'The logic of evidence-based medicine: should it appeal to patients' in Hann A (ed) Analysing health policy Aldershot: Ashgate

Harrison S (1998) Evidence-based medicine in the NHS: towards a history of a policy in Skelton R and Williamson V (eds) Fifty years of the NHS; continuities and discontinuities in health policy. Brighton: University of Brighton

Harrison A and Garside M (2004) The future of health visiting in North Sheffield: report to North Sheffield PCT board http://www.sheffield.nhs.UK/northpct/healthvisitorreport.htm

Hawksley B, Carnwell R and Callwood I (2003) 'A literature review of the public health roles of health visitors and school nurses' British Journal of Community Nursing Vol. 8, No. 10, pp447-453

Health Visitors' Association (1985) The Health Visitor's Role in Child Health Surveillance: a policy statement London: HVA

Hek G, Judd M and Moule P (2002) Making Sense of Research (2nd edition) London: Continuum

Hendrick H (2003) Child Welfare Bristol: The Policy Press

Hendrick H (1997) 'Constructions and reconstructions of British childhood: an interpretative survey, 1800 to the present' in James A and Prout (eds) Constructing and Reconstructing childhood: contemporary issues in the sociological study of childhood (2nd edition) London: Falmer Press

Hendrickse V (1982) 'How effective are our child health clinics?' British Medical Journal Vol. 284, pp575-577

Heussler H, Polnay L and Katz M (2000) 'The times they are a-changing' Children and Society Vol. 14, pp254-266

Higher Education Funding Council for England (2001) Research in Nursing and Allied Professions Bristol: HEFCE

Hill M (1997) Understanding Social Policy (fifth edition) Oxford: Blackwell

Hoddinott P and Pill R (1997) 'A review of recently published qualitative research in general practice. More methodological questions than answers?' Family Practice Vol. 14, No. 4, pp313-319

Holliday I (1995) The NHS Transformed (2nd edition) Chorlton: Baseline Books

Home Office (1998) Supporting Families- a consultation document London: The Stationery Office

Hooper P and Alexander E (1971) 'Developmental assessment in general practice' The Practitioner Vol. 207, pp 371-376

Hudson J and Lowe S (2004) Understanding the Policy Process. Bristol: The Policy Press

Hutchison T (2002) 'Health for all children. Get it right!' British Association for Community Child Health News Vol. 21, No. 1, p3

Hutchison J (1973) 'An experiment in the developmental screening of pre-school children' Health Bulletin Vol. 31, pp156-160

Jacobs R and Hall C (1976) 'Periodic developmental assessment of preschool children in Newham' Public Health Vol. 90, pp179-186

Jadad A (1998) Randomised Controlled Trials: a user's guide London: BMJ Books

James N (1989) 'Emotional labour: skill and work in the social regulation of feelings' Sociological Review Vol. 37, Part 1, pp15-42

Jameson W (1956) An Inquiry into Health Visiting: report of a working party in the field of work, training and recruitment of health visitors London: The Stationery Office

Jenkins S (1984) 'The functions of child health clinics' in McFarlane J (ed) Progress in Child Health, Volume I London: Churchill Livingstone

Johnson A and Paton K (2007) Health Promotion and Health Services: management for change Oxford: Oxford University Press

Kelly M, Morgan A, Bonnefoy J, Butt J and Bergman V (2007) The Social Determinants of Health: developing an evidence base for political action Measurement and Evidence Knowledge Network

Kelsey A (1995) 'Outcome measures; problems and opportunities for public health nursing' Journal of Nursing Management Vol. 3, pp183-187

Kelsey A and Robinson M (1999) 'But they don't see the whole child: health visitors may not welcome systematic reviews of CHS' British Journal of General Practice Vol. 49, Part 438, pp 4-5

Kirkpatrick I, Ackroyd S and Walker R (2005) The New Managerialism and Public Service Professions London: Palgrave Macmillan

Klein R (2001) The New Politics of the NHS (4th edition) Harlow: Prentice Hall

Klein R, Day P and Redmayne S (1996) Managing Scarcity: priority setting and rationing in the NHS Buckingham: Open University Press

Kuo A, Inkelas M, Lotstein D, Samson K, Schor E and Halfon N (2006) Rethinking well-child care in the United States: an international comparison. Pediatrics Vol. 118, pp1692-1702

Kurtz Z and Tomlinson J (1991) 'How do we value our children today? As reflected by children's health, healthcare and policy' Children and Society Vol. 5, Part 3, pp207-224

Lakhani M (2001) 'Modernisation and clinical governance' Journal of Clinical Governance Vol. 9, Part 3, pp113-114

Lamb A (1977) Primary Health Nursing London: Balliere Tindall

Lancet Editorial (1986) The Lancet Part I, pp 950-952

Laurizten S and Sachs L (2001) 'Normality, risk and the future: implicit communication of threat in health surveillance' Sociology of Health and Illness Vol. 23, No. 4, pp 497-516

Law J (1989) 'Surveillance - shifting priorities' Health Visitor Vol. 62, p155

Levitt R, Wall A and Appleby J (1995) The Reorganised National Health Service (5th edition) London: Chapman and Hall

Lewis J (2003) 'Design Issues' in Ritchie J and Spencer J (eds) Qualitative Research Practice London: Sage Publications

Lewis J (1986) 'The working-class wife and mother and state intervention, 1870-1918' in Lewis J (ed) Labour and Love: women's experience of home and family 1850-1940 Oxford: Basil Blackwell

Lewis J (1984) Women in England 1870-1950 Sussex: Wheatsheaf Books

Lewis J (1980) The Politics of Motherhood: child and maternal welfare in England 1900-1939 London: Croom Helm

Li P and Logan S (1996) 'The current state of screening in general practice' Journal of Public Health Medicine Vol. 18, No. 3, pp350-356

Licence K (2004) 'Promoting and protecting the health of children and young people' Child: Care, Health and Development Vol. 30, No. 6, pp623-635

Light D and Hughes D (2002) 'A sociological perspective on rationing' in Hughes D and Light D (eds) Rationing: constructed realities and professional practices Oxford: Blackwell

Lilford R, Richardson A, Stevens A, Fitzpatrick R, Edwards S, Rock F and Hutton J (2001) 'Issues in methodological research; perspectives from researchers and commissioners' Health Technology Assessment Vol. 5, No. 8, pp1-62

Lipsky M (1980) Street-level bureaucracy: dilemmas of the individual in public services New York: Russell Sage Foundation

Lloyd P (1986) 'The management of motherhood: a case study of health visiting to 1914' in While A (ed) Research in Preventive Community Nursing Care Chichester: John Wiley and Sons

Lowenhoff C (2004) 'Have talents: need liberating!' Community Practitioners Journal Vol. 77, No. 1, pp23-25

Luker K (1997) 'Research and the configuration of nursing services' Journal of Clinical Nursing Vol. 6, pp259-267

Lupton C, North N and Khan P (2001) Working Together or Pulling Apart? The NHS and child protection networks Bristol: The Policy Press

Lyon C and Parton N (1995) 'Children's rights and the Children Act 1989' in Franklin B (ed) Handbook of Children's Rights: comparative policy and practice London: Routledge

Macfarlane JA and Pillay U (1984) 'Who does what and how much in the pre-school child health services in England' British Medical Journal Vol. 289, pp 851-852

Malone M (2000) 'A history of health visiting and parenting in the last 50 years' International History of Nursing Journal Vol. 5, No. 3, pp30-43

Malone M, Edwards M, Bliss J, Cheung H, Dooley J, Hobden A, Quioc V and Watts S (2003) 'Health visiting at the crossroads: which way to the 21st century?' British Journal of Community Nursing Vol. 8, No. 4

Marmot M (2004) Status Syndrome London: Bloomsbury Publishing

Marsh C (1979) 'Problems with surveys: methods or epistemology' Sociology Vol. 13, No. 2, pp293-305

Marsh G, Russell D, and Russell I (1989) 'Is paediatrics safe in GPs hands?' Journal of the Royal College of General Practitioners Vol. 39, pp 138-141

Marshall C and Rossman G (1989) Designing Qualitative Research London: Sage

Mason C (1991) 'Project 2000: a critical review' in Nursing Practice Vol. 4, No. 3, pp2-5

Mason J (1994) 'Linking qualitative and quantitative data analysis' in Bryman A and Burgess R (eds) Analysing Qualitative Data London: Routledge

Maxwell J (1997) 'Children and state intervention: developing a coherent historical perspective' in Rafferty A, Robinson J and Elkan R (eds) Nursing History and the Politics of Welfare London: Routledge

May T (1997) Social Research: issues, methods and process (2nd edition) Buckingham: Open University Press

Mayall B (1998) 'Towards a sociology of child health' Sociology of Health and Illness Vol. 20, No. 3, pp269-288

Mayall B (1996) Children, Health and the Social Order. Buckingham: Open University Press

Mayall B (1986) Keeping Children Healthy London: Allen and Unwin

McDonald A, Langford I and Boldero N (1997) 'The future of community nursing in the United Kingdom: district nursing, health visiting and school nursing' Journal of Advanced Nursing Vol. 26, Part 2, pp257-265

Miers M (2000) Gender Issues and Nursing Practice Basingstoke: Macmillan Press

Mill JS (1859) On Liberty London: John W Parker

Mitchell R (1977) 'Community child health services' in Mitchell R (ed) Child Health in the Community London: Churchill Livingstone

Molloy J and Caraher M (2000) Public health and the role of the nurse: the need for greater clarity British Journal of Community Nursing Vol. 5, No. 9, pp431-435

Murphy E, Dingwall R, Greatbatch D, Parker S and Watson P (1998) 'Qualitative research methods in health technology assessment: a review of the literature' Health Technology Assessment Vol. 2, No. 16, pp1-276

Naidoo J and Wills J (2000) Health Promotion: foundations for practice (2nd edition) Edinburgh: Balliere Tindall

National Autistic Society (2005) Checklist for Autism in Toddlers http://www.nas.org.UK/nas/polopoly

Newland R and Cowley S (2003) 'Investigating how health visitors define vulnerability' Community Practitioner Vol. 76, No. 12, pp464-473

NHS Executive (1993) New World, New Opportunities London: HMSO

NHS Management Executive (1992) The Patients' Charter and Primary Health Care London: HMSO

NHSE National screening committee (1977) Evolution or Revolution? Systematic reviews of screening in child health London: Royal College of Paediatrics and Child Health

Nicoll A, Mann S, Mann N and Vyas H (1986) 'The child health clinic: results of a new strategy of community care in a deprived area' The Lancet Vol. 86, part I, pp 606-608

Nielsen J (1990) Feminist Research Methods London: Westview Press

Noble S (2007) 'Freedom Act is too effective for its own good' Community Practitioner Vol. 80, No. 5, p3

Nottingham C and O'Neill F (2000) 'Out of the church and into Kwik Fit: the nursing profession and the secularisation of health care' in Hann A (ed) Analysing Health Policy Aldershot: Ashgate

Nursing and Midwifery Council (2007) '2006-2007 Statistical Analysis of the Register' http://www.nmc-UK.org

Nursing and Midwifery Council (2005) '2004-2005 Statistical Analysis of the Register' http://www.nmc-UK.org

Oakley A (1998) 'Health visiting and social support' Evolution or Revolution 1998: conference report http://www.health-for-all-children.co.UK

Oakley A (1997) 'Making medicine social: the case of the two dogs with bent legs' Clio Med Vol. 43, pp81-96

Oakley A (1981) 'Interviewing women: a contradiction in terms?' in Roberts H (ed) Doing Feminist Research London: Routledge

Oberklaid F (2000) 'Is developmental assessment worthwhile?' Australian Family Physician Vol. 29, No. 8, pp731-734

Oberklaid F (1988) 'Australian paediatricians and the new morbidity: a national survey of changing paediatric practice' Journal of Paediatrics and Child Health Vol. 24, Issue 1, pp5-9
Olds D (2006) 'The Nurse-Family partnership: an evidence-based preventive intervention' Infant Mental Health Journal Vol. 27, No. 1, pp5-25

Oppé T (1967) 'Risk registers for babies' in Developmental Medicine and Child Neurology Vol. 67, No. 9, pp13-21

Parahoo K (1997) Nursing Research Hampshire: Macmillan

Parker R (1995) 'A brief history of child protection' in Farmer E, Owen M (1995) Child Protection Practice: private risks and public remedies London: HMSO

Pearson P (2002) 'What's in a name? – a comment' Community Practitioner Vol. 75, No. 8, pp307

Pearson P and Jones K (1994) 'The primary health care non-team?' British Medical Journal Vol. 309, No. 1966, pp1387-1388

Peckover S (2002) 'Supporting and policing mothers: an analysis of the disciplinary practices of health visiting' Journal of Advanced Nursing Vol. 38, No. 4, pp369-377

Perry A (1993) 'A sociologist's view: the handmaiden's theory' in Jolley M and Brykczynska G (eds) Nursing: its hidden agendas London: Edward Arnold

PHAAR development team (2003) Modernising Health Visiting and School Nurse Practice http://www.southernderbyshire.nhs.UK

Pickard S and Sheaff R (1999) 'Primary Care Groups and NHS rationing' Health Care Analysis Vol. 7, pp37-56`

Plews C, Billingham K and Rowe A (2000) 'Public health nursing; barriers and opportunities' Health and Social Care in the Community Vol. 8, Part 2 pp138-146

Polit D and Hungler B (1995) Nursing Research: principles and methods (5th edition) Philadelphia: JB Lippincott Company

Pollock A (2005) NHS plc: the privatisation of our health care London: Verso

Polnay L (1996) 'Community paediatrics in the UK' Ambulatory Child Health Vol.1, pp 407-414

Polnay L and Pringle M (1989) 'GP training in paediatrics in the Trent region'. British Medical Journal Vol. 298, pp1434-1436

Popay J and Williams G (1998) 'Qualitative research and evidence-based healthcare' Journal of the Royal Society of Medicine Supplement no 35, ol. 91, pp32-37

Porter D (1997) 'Public health and centralisation: the Victorian State' in Holland W, Detels R and Knox G (eds) Oxford Textbook of Public Health (3rd edition) Oxford: Oxford University Press

Porter S and Carter D (2000) 'Common terms and concepts in research' in Cormack D (ed) The Research Process in Nursing Oxford: Blackwell Science

Potrykus C (1989) 'Health for all Children: a threat to effective CHS?' Health Visitor Vol. 62, pp207-209

Pritchard J (2005) 'Strengthening women's health visiting work with women' Journal of Advanced Nursing Vol. 51, No. 3, pp236-244

Rafferty A, Newell R and Traynor M (2004) 'Research and development: policy and capacity building' in Freshwater D and Bishop V (eds) Nursing Research in Context Basingstoke: Palgrave Macmillan

Raikes A (1984) 'Child health surveillance' Midwife, Health Visitor and Community Nurse Vol. 20, p201-202

Reeves R (2007) John Stuart Mill: Victorian firebrand London: Atlantic Books

Rein M (1976) Social Science and Public Policy London: Penguin

Renfrew M, Dyson L, Herbert G, McFadden A, McCormick F, Thomas J and Spiby H (2008) 'Developing evidence-based recommendations in public health- incorporating the views of practitioners, service users and user representatives' Health Expectations Vol. 11, pp3-15

Richards H and Emslie C (2000) 'The doctor or the girl from the university? Considering the influence of professional roles on qualitative interviewing' Family Practice Vol.17, No. 1, pp71-75

Richards I and Roberts C (1967) 'The 'at risk' infant' The Lancet Vol. 2, pp711-713

Riley D (1983) War in the Nursery: theories of mother and child London: Virago

Ritchie J (2003) 'The applications of qualitative research methods' in Ritchie J and Spencer J (eds) Qualitative Research Practice London: Sage Publications

Ritchie J, Lewis J and Elam G (2003) 'Designing and selecting samples' in Ritchie J and Spencer J (eds) Qualitative Research Practice London: Sage Publications

Ritchie J, Spencer L and O'Connor W (2003) 'Carrying Out Qualitative Analysis' in Ritchie J and Spencer J (eds) Qualitative Research Practice London: Sage Publications

Ritchie J and Spencer L (1994) 'Qualitative data analysis for applied policy research' in Bryman A and Burgess R (1994) Analyzing Qualitative Data London: Routledge

Roberts C and colleagues (1996) 'The proof of the pudding' Health Service Journal Vol. 106, part 5494, p27

Robinson J (2000) 'Effective health care and policy action: the example of health visiting' Journal of Advanced Nursing Vol. 32, No. 6, pp1315-1318

Robinson J (1998) 'The social construction through research of health visitor domiciliary visiting' Social Sciences in Health Vol. 4, No. 2, pp90-103

Robinson K (1992) 'The nursing workforce: aspects of inequality' in Robinson J, Gray A and Elkan R (eds) Policy Issues in Nursing Open University Press: Buckingham

Robinson J (1982) An Evaluation of Health Visiting London: CETHV

Roche B, Cowley S, Salt N, Scammell A, Malone M, Savile P, Aikens D and Fitzpatrick S (2005) 'Reassurance or judgement? Parents' views on the delivery of child health surveillance programmes' Family Practice Vol. 22, pp507-512

Rose G (1993) The Strategy of Preventive Medicine Oxford: Oxford University Press

Rose N (1990) Governing the Soul: the shaping of the private self London: Routledge

Ross E (1993) Love and Toil: motherhood in outcast London 1870-1918. Oxford: Oxford University Press

Ross E (1982) 'Fierce questions and taunts: married life in working class London, 1870-1914' Feminist Studies Vol. 8, p578

Rowe J (2003) 'A disappearing act?' Community Practitioner Vol. 76, No. 12, p485

Rowlands P (1975) 'Development assessment in general practice' Update Vol. 10, p379

Royal College of Nursing (2007) Our NHS- today and tomorrow London: RCN

Royal College of General Practitioners (1983) 'Healthier Children- thinking prevention (report of a working party appointed by the Council of the Royal College of General Practitioners)' Report from General Practice 22 Exeter: Royal College of General Practitioners

Ruane S (1997) 'Public-private boundaries and the transformation of the NHS' Critical Social Policy Vol. 17, pp53-78

Ruxton S (1998) Implementing children's rights: what can the UK learn from international experience?' London: Save the Children

Sackett D, Rosenberg W, Gray J, Haynes R and Richardson W (1996) 'Evidence based medicine: what it is and what it isn't' British Medical Journal Vol. 312, pp 71-72

Salter B (1998) The Politics of Change in the Health Service Basingstoke: Macmillan

Salter B (1995) 'The private sector and the NHS: redefining the welfare state' Policy and Politics Vol. 23, No. 1, pp17-30

Salvage J (1998) 'Evidence-based practice: a mixture of motives?' NTresearch Vol. 3, No. 6, pp406-417

Salvage J (1996) 'Labour should listen carefully to nurses' The Independent 10/12/96

Salvage J (1990) 'Treating the malaise in time' Health Service Journal Vol. 100, pp84-85

Salvage J (1992) 'The new nursing: empowering patients or empowering nurses?' in Robinson J, Gray A and Elkan R (eds) Policy Issues in Nursing Open University Press: Buckingham

Sanderson D, Wright D, Acton C and Duree D (2001) 'Cost analysis of child health surveillance' Health Technology Assessment Vol. 5, No. 36, pp1-103

Sapsford R (1999) Survey Research London: Sage

Scottish Executive (2003) 'Health for all Children: guidance on implementation in Scotland, a draft for consultation' http://www.scotland.gov.UK/Publications/2003/12/18669/30701

Secretaries of State for Health (1989) Working for Patients London: HMSO

Sheridan M (1973) From Birth to Five Years: children's developmental progress Windsor: Nfer-Nelson

Sheridan M (1967) 'Risk Registers' British Medical Journal Vol. 2, p505

Sloper P and Statham J (2004) 'The NSF for children, young people and maternity services: developing the evidence-base' Child: Care, Health and Development Vol. 30, No. 6, pp567-570

Smith L and Morrissy J (1994) 'Ethical dilemmas for general practitioners under the new GP contract' Journal of Medical Ethics Vol. 20, pp175-180

Smith K and Sheaff R (2000) 'Some are more equal than others: differing levels of representation in primary care groups' in Hann A (ed) Analysing Health Policy Aldershot: Ashgate

Snowdon S and Stewart Brown S (1998) Pre-school vision screening. Report on systematic reviews seminars, held on December 17th 1997 and January 8th 1998 http://www.health-for-all-children.co.UK

Spencer N and Coe C (2001) 'The development and validation of a measure of parent-reported child health and morbidity: the Warwick child health and morbidity profile' Child: Care, Health and Development Vol. 26, No. 4, pp323-336

Stainton Rogers R (1993) 'The social construction of child- rearing' in Beattie A, Gott M, Jones L and Sidell M (eds) Health and Wellbeing: a reader' Buckingham: Open University

Standing Nursing and Midwifery Advisory Committee (1995) Making it happen. Public health: the contribution, role and development of nurses, midwives and health visitors London: HMSO

Starte G (1976) 'Results from a developmental screening clinic in general practice' The Practitioner Vol. 216, pp 311-316

Steiner H (1977) 'An evaluation of child heath clinic services in Newcastle upon Tyne during 1972-1974'. British Journal of Preventive and Social Medicine. Vol. 31, pp1-5

Stone D (1996) 'Visiting time' Health Service Journal Vol. 106, Part 5498, pp28-29

Stone D and Campbell H (1997) 'Child health promotion and its challenge to medical education: doctors need practical preventive skills they can use in clinical settings' British Medical Journal Vol. 315, Part 7110, pp694-695

Swift B (1996) 'Preparing numerical data' in Sapsford R and Jupp V (eds) Data Collection and Analysis London: Sage

Swingewood A (2000) A Short History of Sociological Thought (3rd edition) Basingstoke: Palgrave

Symonds A (1997) 'Ties that bind: problems with GP attachment' Health Visitor Vol. 70, No. 2, pp53-55

Symonds A (1991) 'Angels and interfering busybodies: the social construction of two occupations' Sociology of Health and Illness Vol. 13, No. 2, pp249-264

Talbot-Smith A and Pollock A (2006) The NHS: a guide Abingdon: Routledge

Thomas N (2002) Children, Family and the State: decision-making and child participation Basingstoke: Macmillan

Titmuss R (1958) Essays on 'The Welfare State' London: Allen and Unwin

Titmuss R (1938) Poverty and Population London: Macmillan

Tudor Hart J and Dieppe P (1996) 'Caring effects' The Lancet Vol. 347, pp1606-1608

Twinn S (1991) 'Conflicting paradigms of health visiting: a continuing debate for professional practice' Journal of Advanced Nursing Vol. 16, pp966-973

Twinn S and Cowley S (1992) The Principles of Health Visiting: a re-examination London: HVA

UNICEF (2007) 'Child poverty in perspective: an overview of child well-being in rich countries' Innocenti Report Card 7 UNICEF: Florence

UNICEF (1991) The State of the World's Children Oxford: Oxford University Press

Unite/CPHVA (2008) Annual Report 2007-2008 London: CPHVA

van Oorschot W (2002) 'Targeting welfare' in Townsend P and Gordon D (eds) World Poverty: new polices to defeat an old enemy Bristol: The Policy Press

Walby S and Greenwell J (1994) Medicine and Nursing: professions in a changing health service London: Sage

Walker C (1986) 'Child health surveillance' Update Vol 133, part 10, pp906-914

Wanless D (2004) Securing Good Health for the Whole Population London: The Stationery Office

Webster C (2002) The National Health Service: a political history Oxford: Oxford University Press

Wells J (1997) 'Priorities, street-level bureaucracy and the community mental health team' Health and Social Care in the Community Vol. 15, Part 5, pp333-342

Welsh Assembly (2005) Children's National Service Framework Implementation Working Group http://www.wales.nhs.UK/sites3/page.cfm?orgid

Welshman J (1997) 'Family visitors or social workers? Health visiting and public health in England and Wales 1890-1974' International History of Nursing Journal Vol. 2, No. 4, pp5-22

White R (1985) The Effects of the NHS on the Nursing Profession1948-1961. London: Kings Fund

Wilmot S (2003) Ethics, Power and Policy: the future of nursing in the NHS Basingstoke: Macmillan

Wilson H (2003) 'Paradoxical pursuits in child health nursing practice: discourses of scientific mothercraft' Critical Public Health Vol. 13, No. 3, pp281-293

Wilson H (2001) 'Power and partnership: a critical analysis of the surveillance discourses of child heath nurses' Journal of Advanced Nursing Vol. 36, Part 2, pp294-301

Wilson J and Junger G (1968) Principles and Practice of Screening for Disease Geneva: WHO

Witz A (1992) Professions and Patriarchy London: Routledge

Woodhead M (1997) 'Psychology and the cultural construction of children's needs' in James A and Prout A (eds) Constructing and Reconstructing Childhood (second edition) London: Routledge

World Health Organisation (1978) The Alma Ata Declaration Geneva: World Health Organisation

Wright C, Jeffrey S, Ross M, Wallis L and Wood R (2009) 'Targeting health visitor care: lessons from Staring Well' Archives of Disease in Childhood Vol. 94, pp23-27

Yin R (1994) Case Study Research (2nd edition) London: Sage

Yin R (1993) Applications of Case Study Research London: Sage

Zwanenberg (1991) 'Effect of the new GP contract on child health clinics' Archives of Disease in Childhood Vol. 66, pp157-161

APPENDIX 2.1

OVERVIEW OF THE PRE-SCHOOL CHILD HEALTH PROMOTION PROGRAMME

(adapted from DH 2004a)

Age	**Intervention**	**By whom**	**Where**
Ante-natal	• Screening and preliminary assessment of child, and family needs. • Provide advice on breastfeeding and general health (including healthy eating and smoking cessation where appropriate) •		
At birth	• General physical examination with particular emphasis on eyes, hearts and hips •		
5-6 days	• Test for hypothyroidism and phenylketonuria •		
New birth visit (usually around 10 days)	• Assessment of child and family health needs, including identification of mental health needs • Information/ support to parents on key health issues (e.g. support for breastfeeding, advice on establishing a routine) •	Midwife or health visitor	At home
6-8 weeks	• General physical examination with particular emphasis on eyes, hearts and hips. • First immunisations. • Review of general progress and delivery of key messages about parenting and health promotion. Identification of post-natal depression or other mental health needs •		
3 months	• Second immunisations. • Review of general progress and delivery of key messages about parenting and health promotion, including weaning		
4 months	• Third immunisations. • Opportunity to give health promotion and advice to parents and to ask parents' concerns		
Age	**Intervention**	**By**	**Where**

		whom	
By 1st birthday	• Systematic assessment of the child's physical, emotional and social development and family needs. This includes actions to address the needs identified and agree future contact with the service. This could be done by early years providers or general practitioners, by contact at clinic, home, by telephone, post or email.	Health visiting team	Clinic or home, or by post, telephone or email
Around 13 months	• MMR (measles mumps and rubella) immunisation. • Review of general progress and health promotion and other advice to parents		
2-3 years	• Review child's progress and ensure that health and developmental needs are being addressed	Health visiting team	
3-5 years	• Booster immunisations. Review of general progress and delivery of key messages about parenting and health promotion		

APPENDIX 3.1

SURVEY QUESTIONNAIRE

NATIONAL SURVEY OF HEALTH VISITORS' WORK WITH PRE-SCHOOL CHILDREN

You have been randomly selected to take part in this survey which aims to find out how health visitors are working with pre-school children across the UK and what your views are on the service provided. **PLEASE take the opportunity to take part in this important research and have your voice heard about current issues affecting our profession**. The questionnaire will take about 10 minutes to complete and a prepaid envelope is enclosed. Any answers you make are confidential and cannot be linked to you personally. What you have to say is very important and your views will be valued.

1 Do you work with pre-school children and their families as part of your current post (either as practitioner or manager)?

Yes □ No □

2 Which of the following best describes your current post? (Please tick one box only)

Health visitor for children and families □1

Health visitor for the elderly □2

Generic health visitor □3

Public health specialist □4

Not currently working as a health visitor □5

Not currently working in the NHS □6

Retired □7

Health visitor manager □8

Other NHS manager □9

Other post □10
(please describe)
……..

If you do not currently work with pre-school children please could you return the questionnaire in the envelope provided. If you have further comments please add them in the open space at the end.
If you are a health visitor currently working with pre-school children or a manager of health visitors working with pre-school children please answer the following questions.

Questionnaire for health visitors and managers working with pre-school children

1 Does your PCT have a child health promotion/child health surveillance programme?

Yes ☐ No ☐

2 Do you use a **developmental assessment tool** as part of the child health promotion/child health surveillance programme?

Yes ☐ No ☐

3 The following table lists some developmental assessment tools that you may use as part of your practice. **Please could you tick any tool that you use.** Please **also** indicate **whether you use this tool routinely on all children** or whether you use it as a targeted assessment where there is a specific need.

	Yes I use	Routine	Targeted	No I don't use
Denver	☐	☐	☐	☐
Schedule of Growing skills	☐	☐	☐	☐
Sheridan	☐	☐	☐	☐
CHAT (checklist for autism in toddlers)	☐	☐	☐	☐
Warwick child health and morbidity profile	☐	☐	☐	☐
Locally devised tool	☐	☐	☐	☐
Other (please describe)	☐	☐	☐	☐

…….

4 Do you make **routine** contact with all children on your caseload at prescribed ages?

Yes ☐ No ☐

4a **If yes** do you make **routine contact with all children** by telephone or face-to-face, or by letter only and at what ages? (please tick all that apply)

	Letter only	telephone only	Face to face	No contact
Before 8 weeks	□1	□2	□3	□4
6 months	□	□	□	□
9 months	□	□	□	□
1 year	□	□	□	□
2 years	□	□	□	□
3 ½ years	□	□	□	□
other (please state age)…….				

5 Do you offer **targeted health visitor contacts** to some children on your caseload who have been identified as having a specific need?

Yes □ No □

5a **If yes** how do you assess which children have a specific need requiring targeting? (please tick all that apply)

the health visitor's professional judgment	Yes □	No □
other judgement (e.g. staff nurse, NNEB)	Yes □	No □
corporate team assessment of need	Yes □	No □
needs assessment tool	Yes □	No □
local protocol	Yes □	No □
child protection assessment framework	Yes □	No □
other (please describe)……	Yes □	No □

5b If a child has been assessed as having **no special need** at what age do you stop offering routine face-to-face health visitor contacts?

Before 8 weeks	□1
4 months	□2
9 months	□3
1 year	□4
2 years	
at school entry	
other (please give age)…….	□7

6 When was your PCTs child health surveillance/promotion programme last revised? **(please tick relevant answer)**

2005 □1 2004 □2 2003 □3 2002 □4 before 2001 □5

programme has not been revised □6 Don't know □7

6a **If the programme has been revised** has there been any change in the number of **routine** or **targeted** contacts with children **recommended in the programme**? Please tick below.

	Increased	No change	Decreased
Routine visits	□1	□2	□3
Targeted visits	□	□	□

7 Please describe to what extent you either agree or disagree with the following statements about health visiting for pre-school children.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
Targeted health visiting is preferable to routine visiting of all children	□1	□2	□3	□4	□5
Health visitors should see children routinely to 4 months and then visit only where there is an identified need	□	□	□	□	□
After 1 year health visitors should visit children only where there is an identified need	□	□	□	□	□
I feel confident in identifying which children to target	□	□	□	□	□
Without routine visiting I find it hard to get to know my families	□	□	□	□	□
Parents know how to seek help for children's problems	□	□	□	□	□
Problems can be missed when children are not seen routinely	□	□	□	□	□

| | Strongly Agree | Agree | Neither agree nor disagree | Disagree | Strongly Disagree |

Playgroup and nursery workers are able to identify problems requiring referral	□1	□2	□3	□4	□5
Targeted health visiting can make clients feel stigmatised	□	□	□	□	□
Reducing routine contacts with children has freed me up to do more public health work	□	□	□	□	□
I have continued to make routine visits to all children because of the needs of the area in which I work	□	□	□	□	□
Changes to the child health promotion/child health surveillance programme have been imposed upon health visitors	□	□	□	□	□
I am given the opportunity to be involved in decisions about my PCTs child health promotion/child health surveillance programme	□	□	□	□	□
Parents have the opportunity to be involved in decisions about my PCTs child health promotion/child health surveillance programme	□	□	□	□	□

8 The following questions ask about the evidence base for different aspects of health visitor work with pre-school children. Please indicate whether you agree or disagree.

	Agree	Neither agree nor disagree	Disagree
It is important that all health visiting interventions are evidence-based	□1	□2	□3
Routine health visitor contacts with children are evidence-based	□	□	□
Targeted health visitor contacts with children are evidence-based	□	□	□

	Agree	Neither agree nor disagree	Disagree

Health visitor public health work is evidence-based	□1	□2	□3
Universal developmental screening is evidence-based	□	□	□

9 In what region is the PCT in which you work? Please tick one box.

Wales	□1
Scotland	□2
Northern Ireland	□3
Northern and Yorkshire	□4
Trent	□5
West Midlands	□6
North West England	□7
Eastern England	□8
London	□9
South East England	□10
South West England	□11
Do not work for PCT	□12

10 Please add any additional comments you would like to make in the space below.

Thank you for completing this questionnaire. Please return it in the pre-paid envelope provided. Your views will provide valuable information about how health visitors across the country are working with pre-school children and their families. **If you wish to enter the prize draw and/or receive a summary of the survey findings please complete the enclosed reply slip and return it in the pre-paid envelope.** If you would prefer to return your reply slip separately please send to Louise Condon at the School for Policy Studies, University of Bristol, 8 Priory Road, Bristol BS8 1TZ.

APPENDIX 3.2

EXPLANATORY LETTER/INFORMATION SHEET (SURVEY)

CHILD HEALTH PROMOTION AND HEALTH VISITORS' WORK WITH PRE-SCHOOL CHILDREN

School for Policy Studies
University of Bristol
8 Priory Road
Bristol
BS8 1TZ.

Dear Registered Health Visitor,

I am inviting you to take part in a research study about the child health promotion carried out by health visitors for pre-school children. This information sheet tells you about the study so you can decide whether you wish to take part. If you are not currently working with pre-school children, either as a practitioner or as a manager then all you need to do is to complete the first page and return the questionnaire in the pre-paid envelope.

What is the purpose of the study?
There have recently been big changes in policy and practice in health promotion/health surveillance for pre-school children. In some areas this has changed the working practices of health visitors. This study aims to find out what services health visitors are offering to pre-school children and how health visitors are practising across the whole, of the UK. Your contribution is vitally impotent in achieving this.

Why have I been chosen?
You are one of the registered health visitors who have been randomly selected from the Nursing and Midwifery Council register to take part in this study. The letters and questionnaires have been sent out by the Nursing and Midwifery Council so your name and address is not known to the researcher and your questionnaire is anonymous.

Do I have to take part?
You do not need to take part in this study but it would be really helpful if you do. If you do not wish to take part, please return the questionnaire in the pre-paid envelope. Alternatively you could simply not send back the questionnaire.

What happens if I want to take part?

Please complete the enclosed questionnaire. The questions are about your role and your practice and it will take you about 10 minutes to fill in. There are no right or wrong answers and all views are valued. When you have completed the questionnaire please return it in the pre-paid envelope to Louise Condon at the School for Policy Studies, University of Bristol, 8 Priory Road, Bristol BS8 1TZ.

Will my questionnaire answers be kept confidential?
All answers will be kept confidential. Your individual answers will not be linked to you or the PCT in which you work. The researcher is not aware of the identity of address of participants. If you wish to return the tear off slip to enter the prize draw and/or receive a summary of the research findings, this slip will be separated from your questionnaire. If you wish you could send this reply slip back in a separate envelope.

What are the advantages and disadvantages of taking part?

If you take part you will add to knowledge about health visitors' practice with regard to health promotion for pre-school children. This is an area which is very little explored, and where more information is needed about health visitors' views and about their practice. **In addition if you choose to fill in the optional tear off slip your name will be entered into a a prize draw and you could win a £50 Marks and Spencer voucher or one of three runner up prizes of a £10 Marks and Spencer voucher.** The disadvantages of taking part are that you need to find the time to fill in the questionnaire and post it!

What will happen to the results of the research study?
The summary findings of the study will be sent to any participant who wishes to receive them. If you wish to receive summary findings please fill in the tear off slip. The full report of the research findings can be obtained by contacting the researcher. The findings of the study will also be reported in the health visiting press.

Who is organising and funding the research?

The research is being carried out by Louise Condon, a researcher based at Bristol University. Funding for the research has been by the Lady Limerick award which is administered by the Community Practitioner and Health Visitor Association.

I hope that you will feel that you want to take part in this study. Thank you very much for taking the time to read this information. If you require more information please contact me at the address or email address below.

Louise Condon
PhD student,
School for Policy Studies,
University of Bristol,
8, Priory Road,
Bristol
BS8 1TZ
Louise.Condon@bristol.ac.UK

APPENDIX 3.3

REPLY SLIP

PRIZE DRAW AND SUMMARY RESEARCH FINDINGS

Please complete the accompanying questionnaire and fill in this reply slip to enter the prize draw. The prizes are;

1st Prize
A £50 Marks and Spencer voucher!

Runner-up prizes
Three runner-up prizes of £10 Marks and Spencer vouchers!

If you would like to be entered in the prize draw you will need to fill in your name and address on the slip below.
(When I receive your questionnaire and the prize draw slip I will separate them immediately so your name will not be connected with the questionnaire. Alternatively you could send the prize draw slip back to me in a separate envelope so it is not received by me with your questionnaire.)

If you would like to receive a copy of the summary research findings when the project is completed please tick the box to say you would like these.

THANK YOU VERY MUCH

…….
REPLY SLIP

Please tick one or both of the boxes below and fill in your name and address.

I would like to be entered in the prize draw □

I would like to be sent a copy of the research findings □

NAME……..

POSTAL OR EMAIL
ADDRESS…….
…….
…….

APPENDIX 3.4

REMINDER LETTER (SURVEY)

NATIONAL SURVEY OF HEALTH VISITORS' WORK WITH PRE-SCHOOL CHILDREN

School for Policy Studies
University of Bristol
8 Priory Road
Bristol
BS8 1TZ.

Dear Registered Health Visitor,

You may remember that I wrote to you in July about this national survey of Health Visitors' views on their work with pre-school children.

As I have not yet heard from you, I am writing to ask you if you would consider completing the enclosed questionnaire and taking part in the survey.

I would be very grateful if you could complete the questionnaire. This research is funded by a grant from the CPHVA, and I want to make good use of this money by producing findings which represent the views of many health visitors.

It is important to get as many responses as possible- your views matter!

It would be helpful if you could return your completed questionnaire within the next two weeks, if possible, in the pre-paid envelope provided. Apologies to those of you who have already sent back the questionnaire and our letters have crossed in the post.

Many thanks,

Louise Condon

P.S. If the questionnaire is not appropriate to you because you are retired or not working with pre-school children, please complete the first page of the questionnaire and send it back to me in the pre-paid envelope or email me at
Louise.Condon@bristol.ac.UK

APPENDIX 3.5

INTERVIEW TOPIC GUIDE

Topic Guide for telephone interview

Discuss consent:
Will last about an hour. 7 sections, about your clients, your work and finding out your views and attitudes. Feel free to express your opinions; there are no right or wrong answers. Can tell me at any time, if you don't want to carry on.
I will tape the interview while we talk. Is that OK? Tape will be transcribed. Your name will not be kept with transcript. Transcript will be numbered. No one will be able to link what you say to your name or your employer. May be linked to area of the country, i.e. North, South, Midlands and Eastern, London. Is that OK?
When write up may use quotes, won't be traceable to you. Is it OK to use direct quotes?

1 Are you currently working as a HV with children and families? FT/PT, Job title
2 Are you working in an urban/inner-city area with high health needs?
3 In what region of the country are you working?
4 Do you provide the Child Health Promotion Programme (CHPP)?
5 Has the CHPP to which you work been revised since 2003?
6 How long have you been qualified as a health visitor?
7 Do you have any other nursing/midwifery/academic/professional qualification?
8 Female/male?
9 Ethnicity?
10 How old are you?

1. Finding out about you
1 Tell me about your clients (who they are, young/old, poverty, ethnicity, CPR, who did you see in the last week, typical week?)
2 What are the sorts of health needs your clients have? (what sort of problems? Health inequalities? common/most serious problems? Parents'/children's problems.)
3 Tell me about how you work (type of caseload e.g. corporate/individual, GP attached, geographical, individual/as a team- if a team- who is on team? Skill mixed?)
4 **What sort of work have you done in the last week? Have you done any preventive work? Have you done any public health work? Any child protection work?** (Individual work, public health, home visits, clinics, imms, health promotion, liaison e.g. A&E, referrals, typical week?)
5 How do you work with other early years services? (education, SSD, Children's Centres, Sure Start, voluntary agencies)
6 **What do you see as the most important part of your work?**
7 Is your work affected by factors such as staffing levels, financial circumstances have an effect on your work? If so, what effect does this have?

2. Your work with clients
1 Do you think of any of your work as child health promotion? If so, what?
2 What do you understand by the 'CHPP'? Who carries it out?
3 What universal services do you offer to pre-school children and their families? (at what ages, numbers of contacts, developmental assessments?) **Targeted services?**

AN-assess	After birth-phys exam	12 days-new birth visit	6-8 weeks-Phys exam, imms	3 months-Imms, review, HP	4 months-Imms, review, HP	By 1 year-assess	13 months-imms, review, HP	2-3 years-review (letter etc)	4-5 years-review (letter etc)

?	**?**	**MW or HV**	**?**	**?**	**?**	**HV team**	**?**	**HV/PHCT**	**?**

4 How do you decide what universal services to offer? (local policy, national policy, practice)
5 How do you decide who gets a targeted service? (assessment, professional judgement, local policy, national policy, practice)
6 Do you think it is important for all pre-school children to be seen regularly by a health visitor? (how often, why)
7 Do you think it is important to make regular assessments of all children's development? (yes/no, why, how regular, what do you do?)

3. The revised CHP programme.
1 Has the programme been revised and, if so, what happened? (What was process of consultation and implementation? who led the implementation/ was involved?)
2 **What was your reaction and other people's reactions to the changes?** (you, HVs, parents, other service providers)
2 What do you think of the CHPP in your area now- has it been made better or worse by the changes?
3 How has it changed the services provided for pre-school children?
4 What has been the impact of the changes on other service providers? (PHCT, referral to secondary health services, SSD, education, voluntary agencies)
5 Have the changes to the CHPP changed the way you do your job? Here are some of the things that might have changed since the revision- what are your views on them? (Examine the baby at new birth visit, EPDS screen on the mother, developmental check at 9 months, 2 year check, age at which stop doing routine visiting, any others you can think of?)
6 What has been the effect of changes to the CHPP on other aspects of your work? (e.g. preventive work, public health, child protection- made easier or harder to do?)

4. CHPP policy
1 Why do you think the CHPP changed? (local/national policy, different professional groups, parents, children)
2 What do you think of the national policy on CHPP? (general view- what is policy, ask view on NSF/ Hall report)
3 Do you think that your local policy on CHPP follows national policy? Eg NSF for children.

AN-assess	**After birth-phys exam**	**12 days-new birth visit**	**6-8 weeks-Phys exam, imms**	**3 months-Imms, review, HP**	**4 months-Imms, review, HP**	**By 1 year-assess**	**13 months-imms, review, HP**	**2-3 years-review**	**4-5 years-review at school entry**
?	**?**	**MW or HV**	**?**	**?**	**?**	**HV team**	**?**	**HV/PHCT**	**?**

4 How does national policy on CHPP affects local policy in your area?
5 How does policy influence how you practice?
6 Do you think policy/the way you work is influenced by evidence from research?
7 Who decides what work HVs should do in your area?

8 How far do you think health visitors choose how they practice?

5. The role of the health visitor
1 What do you think is the health visitor's role in providing a service for pre-school children and families?
2 What do you think health visitors do best?
3 Is there anything health visitors don't do well?
4 What do you think that health visitors do that is different from what other agencies/ workers do?
5 What are the biggest challenges in health visiting?
6 What are the biggest opportunities in health visiting?
7 What have been the main changes in health visiting you have seen in your career?
8 Do you find your work as a health visitor satisfying and if so why?
9 Where do you see yourself working in 5 years time?
10 Looking back would you choose the same career again?

6. Anything else you want to add? Thank you for participating.

APPENDIX 3.6

EXPLANATORY LETTER/INFORMATION SHEET (INTERVIEWS)

CHILD HEALTH PROMOTION AND HEALTH VISITORS' WORK WITH PRE-SCHOOL CHILDREN

School for Policy Studies
University of Bristol
8 Priory Road
Bristol
BS8 1TZ.

Dear Registered Health Visitor,

Having carried out the survey of health visitors' preventive work with pre-school children, I am now inviting health visitors to take part in a second phase of this research study. I would like to interview a small sample of health visitors who work in urban and inner city areas with children and families with high health needs. This information sheet tells you about the study so you can decide whether you wish to volunteer to take part.

What is the purpose of the study?
The national survey examined which services health visitors are offering to pre-school children and how health visitors are practising across the whole of the UK. This second phase of the study seeks to explore in more depth the views and practice of a smaller group of health visitors. Health visitors working in inner city areas have been chosen for this phase of the study, because free text comments added to questionnaires showed that these health visitors were particularly interested in the connection between the Child Health Promotion Programme and health visitors' preventive work with families.

Why have I been chosen?
You have sent me either your email or postal address because you sent me a reply slip with your contact details. I am now contacting you to ask you to email me for a copy of the survey findings, and also asking you whether you would consider taking part in phase II of the study. You can have a summary of the findings whether you take part in the second phase of the study or not. Please email me at Louise.Condon@bristol.ac.UK for a summary of the findings.

Do I have to take part?
You do not need to take part in this study. I am seeking to interview practising health visitors who are working in inner city areas with high health needs. **If you do not wish to take part, please do nothing.**
What happens if I want to take part?
If you would like to volunteer to take part in this second phase of the project, or would like more information about taking part, please email me at Louise.Condon@bristol.ac.UK. From

those who volunteer to take part in the second phase of the project I will randomly select a sample of health visitors to interview by telephone. The telephone interview will take place at home, at a time convenient to you. I expect the interview to last less than an hour. Of course, I will pay for the telephone call!

If I am interviewed will what I say be kept confidential?
All interviews will be kept confidential. What you say will not be linked to you or your employer.

What are the advantages and disadvantages of taking part?
If you take part you will add to knowledge about health visitors' practice with regard to health promotion for pre-school children. This is an area which is very little explored, and where more information is needed about health visitors' views and about their practice. The disadvantages of taking part are that you need to spend time being interviewed.

What will happen to the results of the research study?
The summary findings of the study will be sent to any participant who wishes to receive them. If you wish to receive summary findings please let me know at the end of the interview. The findings of the study will also be reported in the health visiting press.

Who is organising and funding the research?
The research is being carried out by Louise Condon, a researcher based at Bristol University. Funding for the research has been by the Lady Limerick award which is administered by the Community Practitioner and Health Visitor Association.

Thank you very much for taking the time to read this information. If you require more information please contact me at the email address below. If you are a health visitor working with pre-school children and their families in an urban or inner city area with high health inequalities, please consider contacting me. This research cannot happen without your help.

Thank you again for your help so far,

Louise Condon
PhD student,
School for Policy Studies,
University of Bristol,
8, Priory Road,
Bristol
BS8 1TZ

Louise.Condon@bristol.ac.UK

APPENDIX 5.1

PUBLISHED ARTICLE GIVING SURVEY FINDINGS

APPENDIX 5.1

PARTICIPANTS' DESCRIPTIONS OF THE CHILDREN AND FAMILIES WITH THOM THEY WORK

Below is given a table of the type of people health visitors described as their clients. These descriptions were given in response to the question, 'Who are your clients?' A subsequent question was then asked about the ethnicity of clients. Health visitors own words of description are used, and there has been no attempt to standardise descriptions. All names have been changed.

Interviewee	**Characteristics of clients**	**Ethnicity of clients**
Jenny North East	Young single mothers, living on a council estate, also in rented and housing association accommodation	White UK
Siobhan North East	Young parents in rented accommodation, travellers	White UK, some Kurdish fathers, gypsies and Irish travellers
Ruth North West	Mixed caseload- some middle class, also asylum seekers	White UK, Portuguese, Thai, African
Beverley North West	Mixed caseload- single parents, asylum seekers and middle class people	White UK, Chinese, Nigerians and Romanians
Sam North West	Asian families with children	Bangladeshi and Pakistani
Olanna London	Children 0-5 yrs, parents, grandparents, teenage single parents	White UK, Asian, Black African, Black Caribbean, European, Chinese
Maya London	Lone parents, social class 5, asylum seekers, refugees, immigrant workers	Bangladeshi, Pakistani , White UK, Albanians, Yugoslavs, Bosnians, Somali, Afghani, Iraqi, Ethiopian
Karen London	Young lone parents	Asian, White UK
Theresa London	Mixed caseload- housing estate and middle class area	White UK, Eastern European, Somali, Ethiopian, Ghanaian
Alison Midlands	Travellers	Irish travellers, gypsies, New Age travellers, circus people
Jeanette Midlands	Young women with families	White UK, Polish
Interviewee	**Characteristics of clients**	**Ethnicity of clients**

Jess Midlands	Mixed caseload- lone mothers and also affluent area	White UK
Vanessa Midlands	Mixed caseload- lone parents, illegal immigrants and middle class	White UK, Somali, Asian, eastern European
Jane Midlands	Unemployed, living on benefits, single parents	White UK
Hannah South East	Families with pre-school children, travellers	White UK, South East Asian, African, Polish, Albanian, Irish travellers
Paula South East	Families on housing estate, refugees	White UK, Asian, Bangladeshi, African, Somali, Polish
Naomi South East	Young teenage mothers, middle-class, immigrant workers	White UK, Polish, Asian, Black South Africans
Barbara South East	Mixed caseload- white deprived area, and more affluent people in villages; illegal immigrants	White UK, Eastern European, African, Somali, Italian, Asian
Bridget South East	Mixed caseload- young parents on council estate, and more affluent	White UK
Diane South West	Under 5s and families in a deprived area	White UK, Portuguese and Polish
Chris South West	Families with pre-school children, adults, grandparents, school-age children	White UK
Natalia South West	Mixed caseload- consisting of teenage single mothers and working parents and professional families	White UK, Asian
Frances South West	Teenage single parents living on a housing estate; a few owner occupiers	White UK
Kate South West	Mixed caseload- young parents, owner occupiers, immigrants	White UK, Somali, Eastern Europe, North African, Afro-Caribbean, Asian
Megan South West	Rented accommodation and private housing	White UK, African, Indian, Turkish

APPENDIX 5.2

PARTICIPANTS' DESCRIPTIONS OF THE HEALTH NEEDS OF THE CHILDREN AND FAMILIES WITH THOM THEY WORK

This table presents the examples given by health visitors of the types of problems their clients were experiencing. The table has been compiled from interviewees' responses to the question, 'What are your clients' health needs?'. All names have been changed.

Interviewee	**General health needs** **(plus the specific needs of children and parents if given by interviewee)**
Jenny North East	Low income, low educational attainment, domestic violence, alcohol and drug misuse
Siobhan North East	Children- child protection, eye and ear problems Parents- smoking
Ruth North West	Children- poor diet Parents- own difficult childhoods, domestic violence, poverty, poor housing, poor diet
Beverley North West	Children- child protection Parents- domestic violence, mental health
Sam North West	Children- asthma, special needs Parents- mental health, disabilities
Olanna London	Youth crime, domestic violence, post-natal depression
Maya London	Children- child protection Parents- learning disabilities, stress, poverty, being young, social isolation.
Karen London	Children- high infant mortality Parents- deprived backgrounds, non-English speaking
Theresa London	Children- low immunisation rates Parents- own abusive backgrounds, self harm, drug misuse, cervical neoplasms, non-English speaking
Alison Midlands	Accessing health care, literacy, social isolation
Jeanette Midlands	Housing, unemployment, drugs, poor public transport, expensive food, obesity
Jess Midlands	Children- behavioural problems
Interviewee	**General health needs**

	(plus the specific needs of children and parents if given by interviewee)
Vanessa Midlands	Poverty, social deprivation, domestic violence, smoking, poor diet Parents- mental health problems, parenting skills, heart disease, diabetes,
Jane Midlands	Children- child protection
Hannah South East	Children- feeding problems, breastfeeding, behaviour, sleep problems Parents- chaotic lifestyle, non-English speaking
Paula South East	Deprivation Children- child protection
Naomi South East	Children- high infant mortality Parents- post-natal depression, alcohol and drug misuse, mental health problems, domestic violence
Barbara South East	Children- child protection, safety, breastfeeding Parents- smoking, parenting skills
Bridget South East	Children- asthma Parents- abusive backgrounds, mental health, low income
Diane South West	Unemployment, debt, mental health, anxiety, post-natal depression, drug abuse
Chris South West	Children- child protection Parents- poverty, chaotic lifestyle
Natalia South West	Health inequalities, Children- poor nutrition, anaemia Adults- smoking, drug misuse
Frances South West	Housing, unemployment, poor education, poor nutrition, smoking, drug misuse, domestic violence, mental health Children- eczema, asthma, accidents, developmental delay, language delay, glue ear
Kate South West	Parents own disadvantaged childhoods, literacy, poverty, domestic violence, smoking, alcohol and drug abuse, chronic health problems, housing, non-English speaking
Megan South West	Children- behavioural problems Parents- parenting skills, domestic violence, drug and alcohol abuse

APPENDIX 5.3

THE CHPP PARTICIPANTS DESCRIBED THEMSELVES AS DELIVERING

The table below shows the diversity of CHPPs that were being delivered. Where gaps have been left, this indicates that it was not clear exactly what was being offered at that age point. Where AN visits are described as 'universal in policy, variable in practice', this was mainly because interviewees did not have the capacity to do this, but also includes a small number who chose not to carry out universal AN visits because they knew their caseload well and were happy to target. Where the interviewee made clear who a contact was made by, this is included in the table. Contacts between 6 weeks and 6 months have been omitted from the table (despite being specified in the NSF for Children (DH 2004a)) because of the wide variety of different contacts with a variety of health professionals.

All participants stated that at 6-8 weeks babies had a routine check with the GP and the primary course of immunisations began. In a few areas HVs did some elements of this check, e.g. weighing, or were around at baby clinic for the mother to consult at the same time as the check. In one area some HVs had been trained to carry out the 6-8 week check. About half of interviewees visited at home at 6 weeks, to make an assessment of maternal mood (usually the Edinburgh Postnatal Depression Score or a local model in areas of ethnic diversity). Most health visitors described the course of primary immunisations (generally given between 2 and 4 months) as being delivered by the practice nurses, although some HVs immunised at baby clinic. HVs who immunised described immunisation clinics as being too busy to also provide child health promotion. Interviewees did not think practice nurses offered health promotion advice at immunisation contacts.

Key to table
AN = ante-natal
CNN = community nursery nurse
F/U = follow up visit
HCA = health care assistant
HV = health visitor
RGN = registered general nurse

Interviewee	Ante-natal contact	New Birth Visit and F/U	7 months to 1 year	18 months to 2 years	3-5 years
Jenny North East	Universal in policy, variable in practice	HV at home, F/U by RGN	Universal review	Targeted review	Universal review
Siobhan North East	Universal in policy, variable in practice	HV at home, HV F/U	Universal review	Universal review	No contact
Ruth North West	Universal AN	HV at home, F/U discouraged	Universal review	Universal review by CNN	?
Beverley North West	Universal in policy, variable in practice	HV at home, HV F/U	Universal review	Targeted review by CNN	Targeted review
Sam North West	Universal in policy, variable in practice	HV at home, targeted F/U	Universal review	Currently universal, moving to targeted	No contact
Olanna London	Universal in policy, variable in practice	HV at home	Universal review by RGN	Targeted review	Targeted review
Maya London	Targeted AN	HV at home, F/U discouraged	No contact	No contact	No contact
Karen London	Targeted AN	HV home visit, F/U by CNN	Universal review	Group review offered	No contact
Theresa London	Universal AN	HV at home, HV F/U	Universal review	Currently universal, moving to targeted	No contact
Alison Midlands	Targeted AN	HV at home, HV F/U	Universal review	Targeted review	Targeted review
Jeanette Midlands	Universal in policy, variable in practice	HV home visit, F/U by CNN	Universal review by CNN	Universal review by CNN	No contact
Jess Midlands	Universal in policy, variable in practice	?	?	Universal review	?
Vanessa Midlands	Universal in policy, variable in practice	HV at home, HV F/U	Universal review	Targeted review	Targeted review

Interviewee	Ante-natal contact	New Birth Visit and F/U	7 months to 1 year	18 months to 2 years	3-5 years
Jane Midlands	Universal AN (may be phone call)	HV at home, HV F/U	Universal review	Universal review	No contact
Hannah South East	?	HV at home, targeted F/U by HCA	Universal review by HV	No contact	No contact
Paula South East	Universal AN just discontinued	HV at home	No contact	No contact	No contact
Naomi South East	Targeted AN	HV at home	Universal review	Universal review	No contact
Barbara South East	Targeted AN	HV at home, targeted F/U	Universal review	Targeted review	Targeted review
Bridget South East	Universal in policy, variable in practice	HV at home, HV F/U	Universal review	Universal review	Targeted review
Diane South West	Targeted AN	HV at home, HV F/U	Universal review	Targeted review	No contact
Chris South West	Targeted AN	HV home visit, F/U by CNN	Universal review	Targeted review	?
Natalia South West	Targeted AN	HV at home, HV F/U	Universal review by HV	Targeted review by HV	No contact
Frances South West	Universal in policy, variable in practice	HV at home, HV F/U	Universal review by HV	Universal review by CNN	No contact
Kate South West	Universal in policy, variable in practice	HV at home, targeted F/U	Universal review	Targeted review	No contact
Megan South West	Universal AN	HV at home, HV F/U	Universal review	Universal review	Targeted review

APPENDIX 7.1

CHANGES TO THE CHPP

(from DH 2008a, p13)

Moving the CHPP from	**…to**
Commissioning a minimum core programme	Commissioning a universal core programme, plus programmes and services to meet different levels of needs and risk
Variation of provision according to local investment	Variation of provision according to levels of need and risk
A focus on post-birth	An increased focus on pregnancy
A focus on children's services	Greater integration and information sharing with family services- including adult services
A focus mainly on mothers and children	Working routinely with both mothers and fathers (whether they are living together or not)
A programme that looks for problems, deficits and risks	One that looks for and builds on strengths and protective factors- as well as risks
A non-specific approach to emotional issues	The proactive promotion of attachment and the prevention of behavioural problems
A focus on surveillance and health promotion	A greater focus on parenting support, as well as on surveillance and health promotion
A focus on 'contacts'	Health reviews using consultation skills and tools to support behaviour change. Supplementing face-to-face contact with new media and other channels where appropriate
A schedule that is determined by physical development stages and screening tests	A schedule that is determined by social and emotional developmental stages, parental receptiveness and parents' priorities
The assessment of current needs	The assessment of future risks as well as current needs
An emphasis on professionally defined needs	A greater focus on mothers' and fathers' goals and aspirations for their children
Delivered by health practitioners	Led by health visitors, drawing on a range of practitioners, and delivered through general practice and children's centres
The separation of maternity and child health services	Better integration and information sharing between maternity services and the CHPP team, school health teams and adolescent services, including child and adolescent mental health services
A lack of clarity about who is responsible for the quality and outcomes of the CHPP	Health visitors lead the delivery of the CHPP for a defined population across a range of services and locations. The CHPP is commissioned, monitored and evaluated locally, and overseen by the PCT or children's trust in partnership with general practice, including population outcomes.
Minimal supervision of staff or focus on outcomes or quality improvement	Regular supervision, monitoring of quality and outcomes of teams and individual practitioners
Delivered through the primary healthcare team	Delivered by the primary healthcare team and Sure Start children's centres